Date: June 28, 2010

To: Dr. Daniel Brandt, Executive Director

Provider: Campo Behavioral Health
Address: 424 N. Mesilla Street
State/Zip: Las Cruces, New Mexico 88005

E-mail Address: dbrandt@campobh.com

Region: Southwest
Survey Date: April 19 - 21, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living & Independent Living) & Community Inclusion (Adult Habilitation)
Survey Type: Routine
Team Leader: Stephanie R. Martinez de Berenger, M.P.A., GCDF, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Dave L. Brunson, LBSW, Community Inclusion Coordinator, Developmental Disabilities Service Division & Valerie V. Valdez, M.S., Healthcare Program Manager/Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Brandt,

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

Quality Management Approval Rating:
The Division of Health Improvement is issuing your agency a determination of "Non-Compliance with Conditions of Participation," and DDSD Standards and regulations.

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

1. Quality Management Bureau, Attention: Plan of Correction Coordinator
   5301 Central Ave. NE Suite 400 Albuquerque, NM 87108

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 ASAP for approval. All remedies must still be completed within 45 working days of the original submission.

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

Request for Informal Reconsideration of Findings (IRF):
If you disagree with a determination of noncompliance (finding) you have 10 working days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

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

A request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 working days. Providers may not appeal the nature or interpretation of the standard or regulation, the team composition, sampling methodology or the Scope and Severity of the finding.

If the IRF approves the change or removal of a finding, you will be advised of any changes.

This IRF process is separate and apart from the Informal Dispute Resolution (IDR) and Fair Hearing Process for Sanctions from DOH.

Please call the Team Leader at 505-690-7285, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

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

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

Survey Process Employed:

Entrance Conference Date:	April 19, 2010
Present:	**Campo Behavioral Health** Chandra Baker, Executive Director Jennifer Rasmussen, Incident Management Coordinator/Internal Investigations **DOH/DHI/QMB** Stephanie R. Martinez de Berenger, M.P.A., GCDF, Team Lead/Healthcare Surveyor Valerie V. Valdez, M.S., Healthcare Program Manager/Healthcare Surveyor **DDSD – Southwest Regional Office** Dave L. Brunson, LBSW, Community Inclusion Coordinator
Exit Conference Date:	April 21, 2010
Present:	**Campo Behavioral Health** Chandra Baker, Executive Director Jennifer Rasmussen, Incident Management Coordinator/Internal Investigations **DOH/DHI/QMB** Stephanie R. Martinez de Berenger, M.P.A., GCDF, Team Lead/Healthcare Surveyor Valerie V. Valdez, M.S., Healthcare Program Manager/Healthcare Surveyor **DDSD - Southwest Regional Office** Dave L. Brunson, LBSW, Community Inclusion Coordinator Scott Doan, DDSD Southwest Regional Director
Homes Visited	Number: 5
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 5 0 - Jackson Class Members 5 - Non-Jackson Class Members 5 - Supported Living 1 – Independent Living 5 - Adult Habilitation
Persons Served Interviewed	Number: 5
Records Reviewed (Persons Served)	Number: 5
Administrative Files Reviewed	• Billing Records • Medical Records • Incident Management Records • Personnel Files • Training Records • Agency Policy and Procedure • Caregiver Criminal History Screening Records • Employee Abuse Registry • Human Rights Notes and/or Meeting Minutes

- Nursing personnel files
- Evacuation Drills
- Quality Improvement/Quality Assurance Plan

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

Attachment A

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8647.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency ("Responsible Party"), and by WHEN ("Date Due").
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues to prevent the Deficiency from reoccurring, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency's Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to George.Perrault@state.nm.us, by fax (505-222-8661), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been "Approved" or "Denied".
- Whether your POC is "Approved" or "Denied", you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is "Denied" it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8647 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.
- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by-case basis.
- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual numbers.
- Do not submit original documents, hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Attachment B

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

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

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

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

Key to Findings:

"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 not have any findings that meet the thresholds for determining non-compliance with any Condition 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 process, surveyors are openly communicating with providers. Open communication means that surveyors have clarified issues and/or requested missing information before completing the review. Regardless, there may still be instances where the provider disagrees with a specific finding.

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

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

The following limitations apply to the IRF process:

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

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

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

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

Administrative Review Process:
If a Provider desires to challenge the decision of the IRF committee they may request an Administrative Review by the DHI and DDSD Director. The Request must be made in writing to the QMB Bureau Chief and received within 5 days of notification from the IRF decision.

Regarding IRC Sanctions:
The Informal Reconsideration of the Finding process is a separate process specific to QMB Survey Findings and should not be confused with any process associated with IRC Sanctions.

If a Provider desires to Dispute or Appeal an IRC Sanction that is a separate and different process. Providers may choose the Informal Dispute Resolution Process or the Formal Medicaid Fair Hearing Process to dispute or appeal IRC sanctions, please refer to the DOH Sanction policy and section 39 of the provider contract agreement.

Agency: **Campo Behavioral Health - Southwest Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living & Independent Living) & Community Inclusion (Adult Habilitation)
Monitoring Type: Routine Survey
Date of Survey: **April 19 – 21, 2010**

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A03 CQI System	**Scope and Severity Rating: C**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS** **I. Continuous Quality Management System:** Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both	Based on record review, the Agency failed to develop and implement a Continuous Quality Management System. Review of the Agency's Continuous Quality Improvement Plan provided during the on-site survey did not contain the components required by Standards. The Agency's CQI Plan did not contain the following components: (3) Trends in achievement of individual outcomes in the Individual Service Plans;		

supervisory and direct support levels; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction. **7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:** **E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system: **(1)** community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements; **(2)** community based service providers providing developmental disabilities services must have a designated incident management coordinator in place; **(4)** community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.			

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: E		
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	Medication Administration Records (MAR) were reviewed for the months of January, February & March 2010. Based on record review, 4 of 5 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #1 January 2010 • During on-site survey Medication Administration Records were requested for the month of January 2010. Medication Administration Records for the following medications were not provided: ° Lorazepam 2mg (1 time daily): 1/1 - 31, 2010. ° Lunesta 3mg (1 time daily): 1/1 - 31, 2010. ° Nexium 40mg (1 time daily): 1/1 - 31, 2010. ° Fexofenadine HCL 180 mg: (1 time daily) 1/1 - 31, 2010. ° Fluvoxamine 100mg (1 time daily): 1/1 – 31, 2010. ° Advair HFA 230-21 mcg 100mg (2 times daily) 8:00AM dosage: 1/1 – 31, 2010. ° Patanol Opth Soln 1% (2 times daily): 1/1 – 31, 2010. ° Docusate Calc 240mg (2 times daily): 1/1 – 31, 2010. ° Peg Powder 527g (2 times daily): 1/1 – 31, 2010.		

(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 or changed; (x) The name and initials of all staff	° Clozapine 100mg (3 times daily): 1/1 – 31, 2010. ° Astelin Nasal Spray 100mg (2 times daily): 1/1 – 31, 2010. ° Atrovent HFA Inhaler (4 times daily): 8:00AM, 2PM & 8PM dosages 1/1 – 31, 2010 ° Carbamzepine 200mg (3 times daily): 1/1 – 31, 2010. • During on-site survey April 19 – 21, 2010 Physician Orders were requested for the following medications, as of 4/21/2010 the Physician Orders had not been provided: ° Advair HFA 230-21mcg (2 times daily) ° Atrovent HFA Inhaler (4 times daily) February 2010 • During on-site survey Medication Administration Records were requested for the month of February 2010. Medication Administration Records for the following medications were not provided: ° Lorazepam 2mg (1 times daily): 2/1 - 26, 2010. ° Lunesta 3mg (1 times daily): 2/1 -28, 2010. ° Fexofenadine HCL 180mg: (1 times daily) 2/1 - 16, 2010. ° Fluvoxamine 100mg (1 times daily): 2/1 - 22, 2010. ° Advair HFA 230-21 mcg 100mg (2 times daily): 2/1 – 9, 2010. ° Patanol Opth Soln 1% (2 times daily): 2/1 – 23,		

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.	2010. ° Docusate Calc 240 mg (2 times daily): 2/1 – 13, 2010 ° Peg Powder 527g (2 times daily): 2/1 – 15, 2010 ° Clozapine 100mg (3 times daily): 8AM dosage 2/1 - 20, 2010 ° Clozapine 100mg (3 times daily): 12PM dosage 2/1 - 26, 2010 ° Clozapine 100mg (3 times daily) 8PM dosage 2/1 - 25, 2010 ° Astelin Nasal Spray 100mg (2 times daily): 8AM dosage 2/1 – 15, 2010 ° Astelin Nasal Spray 100mg (2 times daily): 8PM dosage 2/1 – 13, 2010. ° Atrovent HFA Inhaler (4 times daily): 8AM dosage 2/1 – 15, 2010. ° Atrovent HFA Inhaler (4 times daily): 2PM dosage 2/1 – 19, 2010. ° Atrovent HFA Inhaler (4 times daily): 8PM dosage 2/1 – 11, 2010. ° Carbamzepine 200mg (3 times daily): 8AM dosage 2/1 – 21, 2010. ° Carbamzepine 200mg (3 times daily): 2PM dosage 2/ – 20, 2010. ° Carbamzepine 200mg (3 times daily): 8PM dosage 2/2 – 22, 2010. • During on-site survey April 19 – 21, 2010		

	Physician Orders were requested for the following medications, as of 4/21/2010 the Physician Orders had not been provided: ° Advair HFA 230-21mcg (2 times daily) March 2010 • During on-site survey Medication Administration Records were requested for the month of March 2010. Medication Administration Records for the following medications were not provided: ° Lorazepam 2mg (1 time daily): 3/29 – 31, 2010. ° Lunesta 3mg (1 times daily): 3/1 – 7, 2010. ° Fexofenadine HCL 180mg: (1 times daily) 3/19 – 31, 2010. ° Fluvoxamine 100mg (1 times daily): 3/25 -31, 2010. ° Advair HFA 230-21 mcg 100mg (2 times daily): 8 AM dosage 3/12 – 31, 2010. ° Patanol Opth Soln 1% (2 times daily): 3/26 - 31, 2010. ° Docusate Calc 240mg (2 times daily): 8AM dosage 3/13 - 31, 2010. ° Peg Powder 527g (2 times daily): 8AM dosage 3/18 - 31, 2010. ° Peg Powder 527g (2 times daily): 8PM dosage 3/1 - 10, 2010. ° Clozapine 100mg (3 times daily): 8AM dosage 3/28 - 31, 2010. ° Atrovent HFA Inhaler (4 times daily): 2PM dosage 3/23 – 31, 2010.		

	• Medication Administration Records did not contain the diagnosis for which the medication is prescribed: ° Simvastatin 20mg (1 time daily) • Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: ° Nexium 40mg (1 time daily) – Blank 3/21, 23, 25, 27, 29, & 31 • During on-site survey April 19 – 21, 2010 Physician Orders were requested for the following medications, as of 4/21/2010 the Physician Orders had not been provided: ° Advair HFA 230-21mcg (2 times daily) Individual #2 January 2010 • During on-site survey Medication Administration Records were requested for the month of January 2010. Medication Administration Records for the following medications were not provided: ° Lorazepam 1mg (3 time daily): 8AM & 2PM dosages 1/1 - 5, 2010. ° Lorazepam 1mg (3 times daily): 8PM dosage 1/1 - 3, 2010. ° Fluvoxamine 100mg (1 time daily): 1/1 – 11, 2010. ° Levothyroxine 50mcg (1 time daily): 1/1 - 10, 2010. ° Propranolol 40mg (3 times daily): 8AM & 2PM		

	dosages 1/1 - 12, 2010. ° Propranolol 40mg (3 times daily): 8:00PM dosage 1/1 - 9, 2010 Individual #3 January 2010 • During on-site survey Medication Administration Records were requested for the month of January 2010. Medication Administration Records for the following medications were not provided: ° Temazepam 30mg (1 time daily): 1/1 - 19, 2010. ° Sertraline 100mg (2 times daily): 8PM dosage 1/1 - 20, 2010 ° Seroquel 400mg (1 time daily): 1/1, 2010. February 2010 • During on-site survey Medication Administration Records were requested for the month of February 2010. Medication Administration Records for the following medications were not provided: ° Seroquel 300mg (1 time daily): 2/22 - 28, 2010. March 2010 • During on-site survey Medication Administration Records were requested for the month of March 2010. Medication Administration Records for the following medications were not provided: ° Temazepam 30mg (1 time daily): 3/21 - 31, 2010. ° Sertraline 100mg (2 times daily): 8AM dosage 3/24 - 31, 2010.		

	° Sertraline 100mg (2 times daily): 8PM dosage 3/22 - 31, 2010. ° Sertraline 400mg (2 times daily): 8AM dosage 3/24 - 31, 2010. ° Seroquel 400mg (2 times daily): 8PM dosage 3/22 - 31, 2010. ° Seroquel 300mg (1 time daily): 3/1 - 31, 2010. Individual #4 January 2010 • During on-site survey Medication Administration Records were requested for the month of January 2010. Medication Administration Records for the following medications were not provided: ° Fexofenadine HCL 180mg (1 time daily): 1/29 - 31, 2010. ° Docusate CALC 240mg (1 times daily): 1/1 - 3, 2010. ° Benzoyl Peroxide Gel 5% (2 times daily): 9PM dosage 1/1 - 7, 2010. ° Benzoyl Peroxide Gel 5% (2 times daily): 8AM dosage 1/1 - 10, 2010. ° Astelin 30ml Nasal Spray (2 times daily): 8PM dosage 1/1 - 26, 2010. ° Abilify 20mg (1 time daily): 1/1 - 4, 2010. ° Divalproex Sodium ER 500MG (1 time daily): 1/1 - 4, 2010. ° Atrovent 0.06% (1 time daily): 1/1 - 4, 2010. ° Flonase 50mcg (1 time daily): 1/1 - 5, 2010		

	March 2010 • During on-site survey Medication Administration Records were requested for the month of March 2010. Medication Administration Records for the following medications were not provided: ° Astelin 30ml nasal Spray (2 times daily): 8PM dosage 3/30 - 31, 2010. ° Monocycline 100mg (2 times daily): 3/25 - 31, 2010. ° Atrovent 0.06% (4 times daily): 8AM & 4PM dosages 3/26 - 31, 2010. ° Atrovent 0.06% (4 times daily): 12PM dosage 3/28 - 31, 2010. ° Atrovent 0.06% (4 times daily): 8PM dosage 3/25 - 31, 2010. ° Levothyroxine 0.112mcg (1 time daily): 3/ 26 - 31, 2010. ° Nortrel 1/35 (1 time daily): 3/26 - 31, 2010.		

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 9 of 91 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Basic Health/Orientation (DSP #127) • Person-Centered Planning (1-Day) (DSP #46) • First Aid (DSP #66) • CPR (DSP #66) • Assisting With Medication Delivery (DSP #64 & 114) • Rights & Advocacy (DSP #52, 118 & 124) • Level 1 Health (DSP #118) • Teaching & Support Strategies (DSP #68 & 118) • Positive Behavior Supports Strategies (DSP #52 & 68) • Participatory Communication & Choice Making (DSP #68)		

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 # 1A26 (CoP) COR / EAR	Scope and Severity Rating: D		
NMAC 7.1.12.8 **REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED**: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.	Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 9 of-93 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** • #46 – Date of hire 04/02/2008. Completed 04/04/2008. • #48 – Date of hire 01/17/2008. Completed 02/19/2008. • #62 – Date of hire 01/29/2010. Completed 02/01/2010. • #73 – Date of hire 08/03/2009. Completed 08/04/2009. • #75 – Date of hire 06/08/2006. Completed 08/09/2006. • #109 – Date of hire 06/12/2007. Completed 06/20/2007. • #119 – Date of hire 10/04/2007. Completed 10/09/2007. • #124 – Date of hire 11/06/2007. Completed 07/16/2008. • #132 – Date of hire 02/15/2008. Completed 04/21/2010.		

E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1.IV. General Provider Requirements.** **D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.			

Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: D		
7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: **A. Duty To Report:** **(1)** All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. **(2)** All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property**,** unexpected and natural/expected deaths; and other reportable incidents to include: **(a)** an environmental hazardous condition, which creates an immediate threat to life or health; or **(b)** admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider. **(3)** All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. **B. Notification**: **(1) Incident Reporting:** Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.	Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 6 individuals. Individual #6 • Incident date 10/03/2009. Allegation was Neglect. Incident report was received 10/06/2009. Late Reporting. IMB Late Report indicated incident of Neglect was "Confirmed."		

Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: D		
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007** **II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.	Based on interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 1 of 93 Agency Personnel. • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#56)		

Tag # 1A28 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: D		
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **E. Consumer and Guardian Orientation Packet:** Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 1 of 5 individuals. • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#3)		

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (2) **Individual-specific training** for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** **A.** Individuals shall receive services from competent and qualified staff. **B.** Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.	Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 6 of 93 Agency Personnel. Review of personnel records found no evidence of the following: • Individual Specific Training (#62, 64, 71, 90, 116 & 127)		

Tag # 5I44 AH Reimbursement	Scope and Severity Rating: C		
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 5 XVI. REIMBURSEMENT**	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 5 of 5 individuals. Individual #1 January 2010 • The Agency billed 164 units of Adult Habilitation. Documentation did not contain a signature/authenticated name of the staff providing the service on 1/4, 15, 18, 20, 25 & 29, 2010 to justify billing. February 2010 • The Agency billed 200 units of Adult Habilitation. Documentation did not contain a signature/authenticated name of the staff providing the service on 2/1, 3, 8, 10, 12, 19, 22 & 26, 2010 to justify billing. March 2010 • The Agency billed 204 units of Adult Habilitation. Documentation did not contain a signature/authenticated name of the staff providing the service on 3/1, 5, 8, 12, 15, 17, 19, 22, 24, 26, 29, 30 & 31, 2010 to justify billing. Individual #2 January 2010 • The Agency billed 468 units of Adult Habilitation. Documentation did not contain a signature/authenticated name of the staff providing the service on 1/1, 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28 & 29, 2010 to justify billing. February 2010 • The Agency billed 452 units of Adult Habilitation. Documentation did not contain a		

A. Billable Unit. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care. **B. Billable Activities** (1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours. (2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours	signature/authenticated name of the staff providing the service on 2/1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25 & 26, 2010 to justify billing. March 2010 • The Agency billed 427 units of Adult Habilitation. Documentation did not contain a signature/authenticated name of the staff providing the service on 3/1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25 & 26, 2010 to justify billing. Individual #3 January 2010 • The Agency billed 453 units of Adult Habilitation. Documentation did not contain a signature/authenticated name of the staff providing the service on 1/1, 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28 & 29, 2010 to justify billing. February 2010 • The Agency billed 306 units of Adult Habilitation. Documentation did not contain a signature/authenticated name of the staff providing the service on 2/1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, & 19, 2010 to justify billing. March 2010 • The Agency billed 372 units of Adult Habilitation. Documentation did not contain a signature/authenticated name of the staff providing the service on 3/1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25 & 26, 2010 to justify billing. Individual #4 January 2010 • The Agency billed a total of 435 units of Adult Habilitation. Documentation did not contain a		

	signature/authenticated name of the staff providing the service on 1/4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28 & 29, 2010 to justify billing. February 2010 • The Agency billed 449 units of Adult Habilitation. Documentation did not contain a signature/authenticated name of the staff providing the service on 2/1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25 & 26, 2010 to justify billing. March 2010 • The Agency billed 434 units of Adult Habilitation. Documentation did not contain a signature/authenticated name of the staff providing the service on 3/1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25 & 26, 2010 to justify billing. Individual #5 January 2010 • The Agency billed 408 units of Adult Habilitation. Documentation did not contain a signature/authenticated name of the staff providing the service on 1/1, 5, 6, 7, 8, 12, 13, 14, 15, 19, 20, 21, 22, 25, 26, 27, 28 & 29, 2010 to justify billing. February 2010 • The Agency billed 384 units of Adult Habilitation. Documentation did not contain a signature/authenticated name of the staff providing the service on 2/2, 3, 4, 5, 9, 10, 11, 12, 16, 17, 18, 19, 23, 24, 25 & 26, 2010 to justify billing. March 2010 • The Agency billed 259 units of Adult Habilitation. Documentation did not contain a signature/authenticated name of the staff		

	providing the service on 3/2, 3, 4, 5, 9, 10, 12, 16, 17, 18, 19, 23, 24, 25 & 26, 2010 to justify billing.		

Tag # 6L14 Residential Case File	Scope and Severity Rating: 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 3 of 5 Individuals receiving Supported Living Services. The following was not found, incomplete and/or not current: • **Current Emergency & Personal Identification Information** ° Did not contain Pharmacy Information (#1 & 2) • Positive Behavioral Plan (#1) • Positive Behavioral Crisis Plan (#1) • **Progress Notes written by DSP and/or Nurses regarding Health Status:** ° Individual #3 - None found for April 2010		

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…			

Tag # 6L26 SL Reimbursement	Scope and Severity Rating: A		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. 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 Supported Living Services for 1 of 5 individuals. Individual #2 February 2010 • The Agency billed 28 units of Supported Living. Documentation on 2/19/2010 did not contain a date to justify billing. March 2010 • The Agency billed 30 units of Supported Living. Documentation on 3/17 & 18, 2010 did not contain a date to justify billing.		

A. **Reimbursement** for Supported Living Services (1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year. (2) **Billable Activities** (a) Direct care provided to an individual in the residence any portion of the day. (b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community. (c) Any activities in which direct support staff provides in accordance with the Scope of Services. (3) Non-Billable Activities (a) The Supported Living Services provider shall not bill DD Waiver for Room and Board. (b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services. (c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.			