Date:	January 18, 2012
To:	Patsy Tarin, Finance Manager/Team Leader
Provider:	Campo Behavioral Health
Address:	424 N. Mesilla Street
State/Zip:	Las Cruces, New Mexico 88005
E-mail Address:	PTarin@campobh.com
CC: Board Chair	Dr. Daniel Brandt
E-Mail Address:	dbrandt@campobh.com
Region:	Southwest
Survey Date:	November 14 – 17, 2011
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Living Supports (Supported Living) & Inclusion Supports (Adult Habilitation)
Survey Type:	Routine
Team Leader:	Valerie V. Valdez, MS, Healthcare Program Manager, Division of Health Improvement/Quality Management Bureau
Team Members:	Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & MariaElena Chavez, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Tarin and Dr. Brandt;

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

Determination of Compliance:
The Division of Health Improvement, Quality Management Bureau has determined your agency is in:
Non-Compliance with all Conditions of Participation

This determination is based on non-compliance with four or more CMS waiver assurances at the Condition of Participation level as well as widespread Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

Plan of Correction:
The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

Submission of your Plan of Correction:
Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. *(See attachment "A" for additional guidance in completing the Plan of Correction)*.

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

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 to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

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

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

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

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

Sincerely,

Valerie V. Valdez, MS

Valerie V. Valdez, MS
Healthcare Program Manager/Team Lead
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	November 14, 2011	
Present:	**Campo Behavioral Health** Patsy Tarin, Finance Manager/Team Leader Teresa Madril, Service Coordinator Randy De La O, Trainer **DOH/DHI/QMB** Valerie V. Valdez, MS, Healthcare Program Manager/Team Lead Deb Russell, BS, Healthcare Surveyor Jennifer Bruns, BSW, Healthcare Surveyor MariaElena Chavez, BSW, Healthcare Surveyor	
Exit Conference Date:	November 17, 2011	
Present:	**Campo Behavioral Health** Patsy Tarin, Finance Manager/Team Leader Teresa Madril, Service Coordinator Anjeanette Hendrix, Service Coordinator Randy De La O, Trainer Sue Rosenberg, Nurse **DOH/DHI/QMB** Valerie V. Valdez, MS, Healthcare Program Manager/Team Lead Deb Russell, BS, Healthcare Surveyor Jennifer Bruns, BSW, Healthcare Surveyor MariaElena Chavez, BSW, Healthcare Surveyor **DDSD - Southwest Regional Office** Zach Robinson, Program Coordinator	
Total Homes Visited	Number:	7
❖ Supported Homes Visited	Number:	7
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	12 0 - *Jackson* Class Members 12 - Non-*Jackson* Class Members 12 - Supported Living 12 - Adult Habilitation
Persons Served Records Reviewed	Number:	12
Persons Served Interviewed	Number:	12
Direct Support Personnel Interviewed	Number:	20
Direct Support Personnel Records Reviewed	Number:	105
Service Coordinator Records Reviewed	Number:	2

Administrative Files Reviewed

- Billing Records
- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Human Rights Notes and/or Meeting Minutes
- Evacuation Drills
- Quality Assurance / Improvement Plan

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

Attachment A

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

Introduction:
After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

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

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

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings. (Providers who fail to complete a POC within the 45 business days allowed shall be referred to the IRC for possible actions or sanctions.)

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

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

Instructions for Completing Agency POC:

Required Content
Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

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

The Plan of Correction must address the required six CMS core elements to address ***each deficiency*** of the POC:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
6. The POC must be signed and dated by the agency director or other authorized official.

The following details should be considered when developing your POC:

- Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
- Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Incident Reporting, and Individual-Specific service requirements, etc;
- How accuracy in Billing documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how ISPs are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to Quality data; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

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

Completion Dates

- The plan of correction must include a **completion date** (entered in the far right-hand column) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, George Perrault at 505-222-8647 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to George Perrault, POC Coordinator in any of the following ways:
    a. Electronically at George.Perrault@state.nm.us *(preferred method)*
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108

5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the POC Coordinator.
6. QMB will notify you when your POC has been "approve" or "denied."
    a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
    b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
    c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
    d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

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

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

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

QMB Determinations of Compliance

- "Compliance with Conditions of Participation"
  The QMB determination of "Compliance with Conditions of Participation," indicates that a provider is in compliance with all 'Conditions of Participation,' (CoP) but may have standard level deficiencies (deficiencies which are not at the condition level) out of compliance. 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 Compliance with Conditions of Participation, the provider must be in compliance with *all* Conditions of Participation.

- "Partial-Compliance with Conditions of Participation"
  The QMB determination of "Partial-Compliance with Conditions of Participation" indicates that a provider is out of compliance with one (1) to three (3) 'Conditions of Participation.' This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

  Providers receiving a repeat determination of 'Partial-Compliance' for repeat deficiencies of CoPs may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- "Non-Compliant with Conditions of Participation":
  The QMB determination of "Non-Compliance with Conditions of Participation," indicates a provider is significantly out of compliance with Conditions of Participation and/or has:
  - Four (4) Conditions of Participation out of compliance.
  - 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.

  The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

  Providers receiving a repeat determination of 'Non-Compliance' will be referred by Quality Management Bureau 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 surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated "Document Request," or "administrative Needs," etc. forms. 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 business days** of receipt of the final Report of Findings.
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.
5. If you have questions about the IRC process, email the IRF Chairperson, Scott Good at scott.good@state.nm.us for assistance.

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received within 10 business 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 DHI/QMB determination of compliance or the length of their DDSD provider contract.

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

The IRF Committee will review the request, 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: **Campo Behavioral Health - Southwest Region**
Program: Developmental Disabilities Waiver
Service: Living Supports (Supported Living) & Inclusion Supports (Adult Habilitation)
Monitoring Type: Routine Survey
Date of Survey: **November 14 – 17, 2011**

Standard of Care	***Deficiencies***	**Agency Plan of Correction, On-going QA/QI & Responsible Party**	**Date Due**
CMS Assurance – Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A08 Agency Case File	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 7 of 12 individuals. Review of the Agency individual case files found the following items were not found, incomplete, and/or not current: • **Current Emergency & Personal Identification Information** ◦ Did not contain Health Plan Information (#2) • **ISP Teaching & Support Strategies** ◦ ***Individual #2 - TASS not found for the following Action Steps:*** ➢ "Goes on a trip" ➢ "Saves (for) a trip" *[sic]* ◦ ***Individual #5 - TASS not found for the following Action Steps:*** ➢ "Take a quiz of complied information" ➢ "Research area hiking trails" ➢ "Choose location, Plan the hike" ➢ "Go on hike"	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training	◦ ***Individual #7 - TASS not found for the following Action Steps:*** ➢ "Will plan snacks for the following week and put the needed items on the shopping list" ➢ "Will prepare snack" ➢ "Will select a location for her day trip" ◦ ***Individual #8 - TASS not found for the following Action Steps:*** ➢ "Prepare dish" ➢ "Apply for positions" ➢ "Interview as opportunities arise" ➢ "Burn slide show on CD" ◦ ***Individual #9 - TASS not found for the following Action Steps:*** ➢ "Prepare food item" ◦ ***Individual #10 - TASS not found for the following Action Steps:*** ➢ "Will choose item to prepare/get needed items" ➢ "Will prepare dish" ◦ ***Individual #12 - TASS not found for the following Action Steps:*** ➢ "Will indentify an activity with roommate" ➢ "Will actively participate in activity for at least 15 minutes" ➢ "Will practice writing the 1st 2 letters of her first name" ➢ "Will practice writing the next 2 letters of her first name" ➢ "Will practice writing the last 3 letters of her first name" ➢ "Will gather supplies for cake" ➢ "Will follow recipe"		

School or Ft. Stanton Hospital. **NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.	➢ "Will decorate her cake" ➢ "Will deliver her cake to desired person" • Positive Behavioral Crisis Plan (#8)		

Tag # 1A32 & 6L14 ISP Implementation	*CoP Level Deficiency*		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan for 10 of 12 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • None found regarding: “will create a 12 page healthy desserts recipe book,” for 7/2011 Individual #3 • Documented Outcomes & Action Steps did not match the current ISP Outcomes and Action Steps. Individual #4 • Per Live Outcome: “will cook one meal of his choice once a week,” was not being completed at the required frequency indicated in the ISP for 7/2011 – 10/2011. Documentation for July, August and September states, “Not Interested.” No documentation found to indicate agency has	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. Enter your Quality Assurance/Quality Improvement processes *below* the line.	

opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	addressed the Individual's non-interest. Individual #5 • Action Steps for outcome: "I will go to a rock show in Tucson, AZ," was not completed at the required frequency for 7/2011 - 10/2011. Individual #7 • None found regarding: "will plan snacks for the following week and put the needed items on the shopping list" for 9/2011 & 10/2011. • None found regarding: "will prepare snack" for 9/2011 & 10/2011. • None found regarding: "will select a location for her day trip" for 9/2011 & 10/2011. Individual #11 • Documented Outcomes & Action Steps did not match the current ISP Outcomes and Action Steps. Live outcome addresses the caring for a dog. Agency outcome and tracking address the individual caring for a fish. Individual #12 • None found regarding: "will engage in an activity of common interest with her roommate," for 7/2011 – 10/2011. • None found regarding: "will make, bake and decorate a cake," for 7/2011 – 10/2011. **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1		

	• None found regarding: "will obtain a part time job," for 8/2011 & 9/2011 Individual #4 • Per action steps: 1) "attend and participate in animal therapy twice a month for one year," and 2) "will plan and attend one out of ten activities a month," was not being completed at the required frequency indicated in the ISP for 7/2011 – 10/2011. Documentation for July, August, September and October states, "Not Interested." No documentation found to indicate agency has addressed individual's non-interest. Individual #5 • Action Steps for outcome: "I will go to a rock show in Tucson, AZ," was not completed at the required frequency for 7/2011 - 10/2011. • Action Steps for outcome: "I will go on a monthly hike to look for and collect rocks locally and in surrounding areas," was not completed at the required frequency for 7/2011 - 10/2011. • Action Steps for outcome: "I want to find a job," was not completed at the required frequency for 7/2011 - 10/2011. Individual #7 • None found regarding: "will select a location for her day trip," for 9/2011 & 10/2011. Individual #8 • None found regarding: "will apply for positions," for 10/2011.		

	Individual #11 • None found regarding: "will save money monthly until I have enough for a trip with travel companion support," for 8/2011 & September 2011. Individual #12 • None found regarding: "will learn to write her 1st name," for 7/2011 – 10/2011. **Residential Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #4 • None found for 11/1/2011 – 11/15/2011. Individual #5 • None found regarding: "Take a quiz of compiled information," for 11/1/2011 – 11/15/2011 Individual #6 • None found for 11/1/2011 – 11/14/2011. Individual #7 • None found for 11/1/2011 – 11/15/2011. Individual #8 • None found for 11/1/2011 – 11/14/2011. Individual #9 • None found for 11/1/2011 – 11/15/2011.		

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **E. Provider Agency Reporting Requirements:** All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and…	Based on record review, the Agency failed to complete quarterly reports as required for 5 of 12 individuals receiving Community Inclusion services. **Adult Habilitation Quarterly Reports** • Individual #2 - None found for 5/2011 - 10/2011 • Individual #3 - None found for 7/2011 – 10/2011. • Individual #8 - None found for 11/2010 – 10/2011. • Individual #9 – None found for 9/2010 – 8/2011. • Individual #12 – None found for 5/2011 – 7/2011.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Tag # 6L04 Community Living Scope of Service	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. II. SCOPE OF COMMUNITY LIVING SERVICES**. **A**. The scope of Community Living Services includes, but is not limited to the following as identified by the IDT: (1) Assist with money management, including financial record keeping; (2) Assistance to attain and maintain safe and sanitary living conditions that may include general housekeeping, shopping, washing and drying laundry; (3) Assistance to maintain activities of daily living such as bathing, eating, meal preparation, dressing, and individual hygiene; (4) Assistance with mobility and orientation in community integration, access and utilization of natural supports (5) Assistance in developing and maintaining social, spiritual and individual relationships, to include the development of generic and natural supports of his or her choosing; (6) Assistance to access recreational and leisure activities; (7) Assistance in access to training and educational opportunities on self-advocacy and sexuality; (8) Implementation of the ISP Therapy, Meal-time, Positive Behavioral Supports, Health Care, and Crisis Prevention/Interventions Plans, if applicable;	Based on interview, the Agency failed to provide Community Living Services within the Scope of Service for 7 of 12 individuals. During interviews with the Individuals the following was found: **When Individuals were asked if they liked the services they were getting from the agency, the following was reported:** • Individual #4 stated, "No they take all my money." • Individual #5 stated, "Sometimes." **When Individuals were asked if they liked the staff who help them, the following was reported:** • Individual #4 stated, "No." • Individual #5 stated, "Sometimes, that too." **When Individuals were asked if they liked living in the home they lived in the following was reported:** • Individual #4 stated, "No, cause (named another individual who lives in the home) here." When asked if he had discussed this with the agency or his team, the individual stated, "Yes." • Individual #5 stated, "I do, but not with this roommate (#10). If I could, I would like to live by myself in a one bedroom apartment." **When Individuals were asked if they picked who they lived with and if they got along with**	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

(9) Assistance in developing health maintenance supports, as well as monitoring the effectiveness of such supports; (10) Provide or arrange for transportation for, but not limited to, Community Inclusion, leisure and recreation activities, medical, dental, and therapy appointments; (11) Assistance in medication management and pharmacy needs in accordance with the DDSD's Medication Assessment and Delivery Policy; (12) Assist the individual as needed, in coordination with the designated healthcare coordinator and others on the IDT, with access to medical, dental, therapy, nutritional, behavioral and nursing practitioners and in the timely implementation of healthcare orders, monitoring and recording of therapeutic plans or activities as prescribed, to include: health care and crisis prevention/ intervention plans; (13) Support individuals to participate in the development of house rules, schedules and planned activities; and (14) For individuals with a HAT score of 5 or 6, the agency nurse shall participate in the annual ISP meeting and any other IDT meetings called to address a change in health condition/new diagnosis. Such participation will preferably occur in person or by phone, but if that is not possible, may occur via provision of information to the team prior to the meeting with follow up contact afterwards.	**them the following was reported:** • Individual #1 stated, "No." • Individual #4 stated, "No, No." • Individual #5 stated, "No, Campo chose him. Not real well." • Individual #6 stated, "No." • Individual #8 stated, "No, someone is supposed to be helping with that." • Individual #10 stated, "We don't get along that often." • Individual #12 stated, "No." **When Individuals were asked if they can visit friends and family when they want to the following was reported:** • Individual #5 stated, "No, no one wants to take me to T or C." **When Individuals were asked if they get to go to their meetings to talk about what they want, if the team listens to them and if they get what they need the following was reported:** • Individual #5 stated, "Sometimes, not all the time."		

Tag # 6L14 Residential Case File	Standard Level Deficiency		
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	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 10 of 12 Individuals receiving Supported Living Services. The following was not found, incomplete and/or not current: • **Current Emergency & Personal Identification Information** ◦ Did not contain Primary Care Physician Information (#10) • Annual ISP (#1, 3 & 9) • Individual Specific Training Section of ISP (#1 & 3) • Positive Behavioral Plan (#1, 2, 5, 6, 8 & 11) • Positive Behavioral Crisis Plan (#1, 2, 3, 5, 6, 8 & 11) • Speech Therapy Plan (#8 & 11) • **Special Health Care Needs** ◦ Nutritional Plan (#11 & 12) ◦ Oral Care Plan (#11) • **Health Care Plans** ◦ Seizures. Per IST section of ISP (#5) • **Crisis Plan/Medical Emergency Response Plans** • Falls (#5)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration			

is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.			

Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **D. Community Living Service Provider Agency Reporting Requirements:** All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation: (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members.	Based on record review, the Agency failed to complete written quarterly status reports for 6 of 12 individuals receiving Community Living Services. **Supported Living Quarterly Reports:** • Individual #3 - None found for 7/2011 – 10/2011. • Individual #8 - None found for 8/2011 - 10/2011 • Individual #9 – None found for 9/2010 – 2/2011. • Individual #12 – None found for 12/2010 – 3/2011. **Support Living Annual Assessment** • Individual #1 - None found for 2/2010 – 2/2011 • Individual #2 - None found for 8/2010 - 8/2011 • Individual #8 - None found for 2/2010 - 2/2011 • Individual #9 – None found for 11/2009 – 11/2010. • Individual #12 – None found for 10/2010 – 10/2011.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A11.1 Transportation Training	**Standard Level Deficiency**		
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… **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy** Training Requirements for Direct Service Agency Staff Policy **Eff Date:** March 1, 2007 **II. POLICY STATEMENTS:** 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. The training shall address at least the following: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or	Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 98 of 105 Direct Support Personnel. **No documented evidence was found of the following required training:** • Transportation (DSP #40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 81, 82, 83, 84, 85, 86, 88, 89, 90, 91, 92, 93, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 142, 143 & 144) **When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported:** • DSP #136 stated, "No." • DSP #118 stated, "No." • DSP #131 stated, "No."	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)	• DSP #85 stated, "No." • DSP #129 stated, "No, not with Campo." • DSP #123 stated, "Just put seat belt." • DSP #144 stated, "No."		

Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency		
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**	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 75 of 105 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certifications being completed: • Pre- Service (DSP #47, 56, 66, 131, 137, 138, 139, 140, 142 & 144) • Foundation for Health & Wellness (DSP #45, 47, 55, 56, 65, 66, 70, 131, 132, 135, 136, 137, 138, 139, 140, 142 & 144) • Person-Centered Planning (1-Day) (DSP #40 44, 52, 54, 55, 63, 70, 78, 83, 86, 100, 120, 122, 123, 125, 131, 132, 137 & 144) • First Aid (DSP #44, 46, 49, 52, 55, 57, 69, 70, 71, 72, 74, 76, 80, 81, 82, 84, 85, 87, 90, 92, 94, 96, 98, 101, 102, 106, 109, 111, 112, 113, 115, 119, 125, 126, 127, 128, 130, 131 & 144) • CPR (DSP #44, 46, 49, 52, 55, 57, 59, 69, 70, 71, 72, 74, 76, 80, 81, 82, 84, 85, 87, 90, 92, 94, 96, 98, 101, 102, 106, 109, 111, 112, 113,114, 115, 119, 124, 125, 126, 127, 128, 130, 131 & 144) • Assisting With Medication Delivery (DSP #45, 48, 49, 64, 68, 69, 74, 80, 87, 88, 92, 94, 96, 101, 103, 106, 112, 113, 116, 125, 126 & 129)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. Enter your Quality Assurance/Quality Improvement processes *below* the line.	

- 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. 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…	• Participatory Communication & Choice Making (DSP #72, 75, 93, 100, 111, 118 & 144) • Rights & Advocacy (DSP #54, 93, 100 & 144) • Level 1 Health (DSP #72, 75, 93, 100, 111, 118, 120, 122 & 144) • Positive Behavior Supports Strategies (DSP #72, 75, 100, 111, 118, 120, 122 & 144) • Teaching & Support Strategies (DSP #75, 100, 118, 122, 124 & 144)		

Tag # 1A22 Agency Personnel Competency	Standard Level Deficiency		
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. **F. Qualifications for Direct Service Personnel:** The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency: (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative	Based on interview, the Agency failed to ensure that training competencies were met for 6 of 20 Direct Support Personnel. **When DSP were asked if they received training on the Individual's ISP and what the plan covered, the following was reported:** • DSP #124 stated, "No, they recorded the ISP meeting so any day now we're suppose to go back and listen." (Individual #4) • DSP #51 stated, "I just read it myself when I was here." (Individual #10) **When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:** • DSP #118 stated, "Don't know off hand." DSP #118 attempted to locate HCP(s) in the file, but could not find them. As indicated by the Agency file, the Individual has Health Care Plans for BMI, Neuro, Seizures, Constipation and falls. (Individual #3) • DSP #124 stated, "No." As indicated by the Agency file, the Individual has a Health Care Plan for Seizures. (Individual #4) **When DSP were asked if the Individual had Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:** • DSP #118 stated, "Not sure…not that I know of." As indicated by the Agency file, the	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. Enter your Quality Assurance/Quality Improvement processes *below* the line.	

communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and (5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support. (6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows: (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.	Individual has Medical Emergency Response Plans for Neuro, Seizures and falls. (Individual #3) **When DSP were asked if the Individual had Aspiration, the following was reported:** • DSP #136 stated, "Yes." According to the eChat and ISP, the individual does *not* have a diagnosis of Aspiration. (Individual #1) **When DSP were asked what steps they are to take if the Individual is Aspirating specific to the Individual's plan, the following was reported:** • DSP #83 stated, "Do the Heimlich-maneuver and clear the airway." Per the Individual's Aspiration plans the Heimlich Maneuver is not discussed. (Individual #11) **When DSP were asked if the Individual had Bowel and Bladder issues and if so, what are they to monitor, the following was reported:** • DSP #135 stated, "No." According to the Individual's eChat the Individual has bowel & bladder issues. (Individual #12)		

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.			

Tag # 1A25 Criminal Caregiver History Screening	*CoP Level Deficiency*		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:** **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery;	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to maintain documentation indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 12 of 107 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** **Direct Support Personnel (DSP):** • #47 – Date of hire 10/11/2011. • #57 – Date of hire 6/15/2011. • #66 – Date of Hire 8/3/2011. • #70 – Date of Hire 7/21/2011. • #77 – Date of Hire 7/21/2011. • #98 – Date of Hire 7/21/2011. • #138 – Date of Hire 10/11/2011. • #140 – Date of Hire 9/13/2011. • #142 – Date of Hire 9/19/2011.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.	• #144 – Date of Hire 8/4/2010. **Service Coordination Personnel (SC):** • #145 – Date of hire 2/14/2008. • #146 – Date of hire 7/12/2010.		

Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	*CoP Level Deficiency*		
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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. 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 27 of 107 Agency Personnel. **The following Agency personnel records contained *no* evidence of the Employee Abuse Registry being completed:** **Direct Support Personnel (DSP):** • #47 – Date of hire 10/11/2011 • #57 – Date of hire 6/15/2011 • #66 – Date of hire 8/3/2011 • #88 – Date of hire 9/12/2006 • #138 – Date of hire 10/11/2011 • #142 – Date of hire 9/19/2011 • #144 – Date of hire 8/4/2010 **Service Coordination Personnel (SC):** • #145 – Date of hire 2/14/2008 • #146 – Date of hire 7/12/2010 **The following Agency Personnel records**	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals 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	**contained evidence that indicated the Employee Abuse Registry was completed *after* hire:** **Direct Support Personnel (DSP):** • #40 – Date of hire 3/17/2011, completed 4/4/2011. • #51 – Date of hire 9/19/2011, completed 10/18/2011. • #52 – Date of hire 3/31/2011, completed 4/28/2011. • #55 – Date of hire 1/20/2011, completed 1/25/2011. • #58 – Date of hire 10/11/2011, completed 10/18/2011. • #63– Date of hire 3/17/2011, completed 4/4/2011. • #65 – Date of hire 9/19/2011, completed 10/18/2011. • #83 – Date of hire 3/17/2011, completed 4/4/2011. • #84 – Date of hire 6/23/2011, completed 7/8/2011. • #99 – Date of hire 6/5/2007, completed 7/13/2007. • #101 – Date of hire 6/15/2011, completed 7/8/2011.		

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.	• #125 – Date of hire 3/17/2011, completed 4/4/2011. • #126 – Date of hire 3/17/2011, completed 4/4/2011. • #127 – Date of hire 7/6/2011, completed 7/22/2011. • #131 – Date of hire 6/23/2011, completed 7/8/2011. • #135 – Date of hire 9/29/2011, completed 10/18/2011. • #136 – Date of hire 9/29/2011, completed 10/18/2011. • #140 – Date of hire 9/13/2011, completed 10/18/2011.		

Tag # 1A28.1 Incident Mgt. System - Personnel Training	*CoP Level Deficiency*		
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:**	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 43 of 107 Agency Personnel. **Direct Support Personnel (DSP):** • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#43, 47, 48, 51, 56, 61, 64, 66, 69, 73, 74, 75, 76, 88, 94, 95, 96, 98, 106, 109, 112, 113, 114, 115, 117, 119, 120, 121, 122, 125, 127, 129, 130, 137, 138, 139, 140 & 142) **Service Coordination Personnel (SC):** • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#145) **When Direct Support Personnel were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect & Misappropriation of Consumers' Property, the following was reported:** • DSP #121 stated, "Give it to the Service Coordinator." Staff was not able to identify the State Agencies as APS and DHI. • DSP #118 stated, "Report everything to Teresa." Staff was not able to identify the two State Agencies as APS & DHI.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

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.	• DSP #103 stated, "Can't think of it right now." Staff was not able to identify the two State Agencies as APS & DHI. • DSP #83 stated, "Call the nurse, maybe." Staff was not able to identify the two State Agencies as APS & DHI. • DSP #135 stated, "No, not sure." Staff was not able to identify the two State Agencies as APS & DHI.		

Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Standard Level Deficiency		
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 6 of 12 individuals. • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property): (#1, 2, 3, 4, 7 & 12)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Tag # 1A37 Individual Specific Training	*CoP Level Deficiency*		
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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 67 of 107 Agency Personnel. Review of personnel records found no evidence of the following: **Direct Support Personnel (DSP):** • Individual Specific Training (#40, 41, 43, 44, 45, 47, 48, 50, 51, 52, 53, 54, 55, 56, 57, 58, 62, 63, 65, 66, 68, 69, 70, 71, 72, 75, 77, 78, 83, 84, 86, 90, 91, 93, 94, 95, 98, 100, 101, 105, 109, 111, 112, 114, 115, 118, 120, 122, 124, 125, 126, 127, 129, 131, 132, 133, 135, 136, 137, 138, 139, 140, 142, 143 & 144) **Service Coordination Personnel (SC):** • Individual Specific Training (#145 & 146)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

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

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 1A03 CQI System	**Standard Level Deficiency**		
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	Based on record review, the Agency failed to update and implement their Continuous Quality Management System on an annual basis. In addition, the Agency failed to establish and implement a quality improvement system for reviewing alleged complaints and incidents The Agency's Continuous Quality Improvement Plan Policy and Procedure provided during the on-site survey November 14 – 17, 2011 was dated 6/11/2007 and contained no evidence indicating the document had been updated. Review of documents found the Agency's CQI team met and developed a Health Care Supports – Quality Assurance Plan to address specific medication issues, as well as medical concerns, nevertheless, no evidence was found showing evidence of the implementation of the Health Care Supports QA Plan. Additionally, the agency developed policies and procedures to address the components of the DDSD Continuous Quality Management System, yet the policies do not contain the agency's "Leadership Council Approval" and/or date of implementation. No evidence of the following was found: (1) community based service providers funded through the long-term services division to	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

incidents leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction. **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	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; **When #145 & 147 were asked if the Agency had evidence of the implementation of their Continuous Quality Improvement Plan and Incident Management Quality Improvement System, which included a process for reviewing alleged complaints & incidents; documentation of internal investigations of alleged violations; reasonable steps taken to prevent further incidents and documentation of corrective actions, the following was reported:** • #147 stated, "We are going through a lot of changes at the moment and as you know we had some significant administrative changes this week. We have some information, it's a matter of finding it. We do meet, we audit files and we do surprise visits." #145 sat in on the interview and nodded her head in agreement with responses. **When #145 & 147 were asked who the Agency's Incident Management Coordinator was, the following was reported:** • #145 & 147 reported the Agency's Service Coordinators are acting in the role, "no one specific." Additionally it was reported the agency was in the process of hiring an individual to handle Incident Management.		

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 # 1A05 General Requirements	Standard Level Deficiency		
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. **A. General Requirements:** (2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDSD policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.	Based on record review, the Agency failed to review and update its written policies and procedures every three years or as needed. The following policies and procedures provided during the on-site survey showed no evidence of being reviewed every three years or being updated as needed: • Medication Policy - Assisting with Medication- Last reviewed 5/4/2006. • Vehicle Safety Procedures (Transportation) - Last reviewed 7/1/2005. • Complaint and Grievance Policy - Last reviewed 7/9/2007. • Human Rights Committee - Last reviewed 7/9/2007. • Representative Payee Policy - Last reviewed 7/9/2007. • Emergency Procedure - Last reviewed 7/9/2007.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	*CoP Level Deficiency*		
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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of September, October & November 2011. Based on record review, 7 of 12 individuals had Medication Administration Records which contained missing medications entries and/or other errors: Individual #1 September 2011 Medication Administration Records indicates the following medication was given, notes on back of MAR indicate the med was not given as the individual was out of the medication: • Gabapentin 600mg (3 times daily) – 9/20/2011. October 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Lithium Carbonate 150mg (1 time daily) – Blank 10/17, 18 & 19 (8AM) Individual #2 October 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Loprox 1.00 Cream (2 times daily) – Blank 10/8 (8PM) & 10/9 & 13 (8AM & 8PM)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

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 documentation shall include:	Medication Administration Records indicates the following medication was given, notes on back of MAR indicate the med was not given as the individual was out of the medication: • Loprox 1.00 (2 times daily) – 10/10, 11 & 12 Individual #7 September 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Gabapentin 600mg (2 times daily) – Blank 9/4 (8AM) • Phenytoin Dilantin 125mg/5mL (1 time daily) – Blank 9/5, 23 & 30 (8PM) Individual #8 October 2011 Medication Administration Records contains initials indicating the following medication was given, count on MAR indicates zero medications, documentation indicates medication was not given as the individual was out of the medication: • Advair Diskus 250/50 (2 times daily) – 10/9 (8AM & 8PM). Individual #9 September 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Artane (trihexyphenidyl) 2mg (1 time daily) – Blank 9/2 (8AM) • Buspar 15mg (3 times daily) – Blank 9/2 (2PM)		

(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.	Individual #11 September 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Aspirin (1 time daily) – Blank 9/28 & 29 (8AM) Individual #12 October 2011 Medication Administration Records initials indicate the following medication was given, MAR includes count which indicates zero medications present. Document indicates med was not given: • Fexofenadine 60mg (2 times daily) – 10/16 (8AM & 8PM). November 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Hydrocortisone 2.5% Cream (2 times daily) – Blank 11/11 & 13 (8AM)		

Tag # 1A09.1 Medication Delivery - PRN Medication	*CoP Level Deficiency*		
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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 10 of 12 Individuals. Individual #1 September 2011 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Azithromycin 250mg – PRN – 9/15, 16, 17, 18 & 19 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Azithromycin 250mg – PRN – 9/15, 16, 17, 18 & 19 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Azithromycin 250mg – PRN – 9/15, 16, 17, 18 & 19 (given 1 time) • Acetaminophen 325mg – PRN – 9/24 (given 1 time) • Sore Throat Spray – PRN – 9/7 (given 1 time) • Guiatuss – PRN – 9/24 (given 1 time) October 2011	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

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,	No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Milk of Magnesia – PRN – 10/28 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 200mg – PRN – 10/14, 26 & 24 (given 1 time) • Acetaminophen 325mg – PRN – 10/29 (given 1 time) • Milk of Magnesia – PRN – 10/28 (given 1 time) Individual #2 September 2011 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Penicillin VK 500mg – PRN – 9/2 & 6 (given 3 times); 9/3, 4 & 5 (given 4 times) • Ciclopirox 0.77% - PRN – 9/10, 11, 12, 13 & 14 (given 1 time) & 9/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Penicillin VK 500mg – PRN – 9/2 & 6 (given 3 times); 9/3, 4 & 5 (given 4 times) • Ciclopirox 0.77% - PRN – 9/10, 11, 12, 13 & 14 (given 1 time) & 9/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30		

including over-the-counter medications. This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **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	(given 2 times) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Penicillin VK 500mg – PRN – 9/2 & 6 (given 3 times); 9/3, 4 & 5 (given 4 times) • Ciclopirox 0.77% - PRN – 9/10, 11, 12, 13 & 14 (given 1 time) & 9/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times) Individual #3 September 2011 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Ativan 0.5mg – PRN – 9/16 (given 1 time) & 9/17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times) • Acetaminophen 325mg – PRN – 9/10 & 11 (given 1 time) • Triple Antibiotic Ointment – PRN – 9/11 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ativan 0.5mg – PRN – 9/16 (given 1 time) & 9/17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times) • Acetaminophen 325mg – PRN – 9/10 & 11 (given 1 time) • Triple Antibiotic Ointment – PRN – 9/11 (given 1 time)		

with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual. 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and	No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 325mg – PRN – 9/10 & 11 (given 1 time) • Triple Antibiotic Ointment – PRN – 9/11 (given 1 time) October 2011 No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 325mg – PRN – 10/15 (given 1 time) Individual #5 October 2011 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 400mg – PRN – 10/2 & 8 (given 1 time) • Ibuprofen 200mg – PRN – 10/30 (given 1 time) Individual #6 September 2011 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Ibuprofen 200mg – PRN – 9/29 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 200mg – PRN – 9/29 (given 1		

independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:** **Medication Assessment and Delivery** **Procedure Eff Date: November 1, 2006** C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications). a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).	time) October 2011 No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 200mg – PRN – 10/18 (given 1 time) • Pink Bismuth – PRN – 10/21 (given 1 time) Individual #7 September 2011 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Zyprexa 5mg – PRN – 9/1, 6, 8, 11, 13, 15, 21 & 28 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Zyprexa 5mg – PRN – 9/1, 6, 8, 11, 13, 15, 21 & 28 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Zyprexa 5mg – PRN – 9/1, 6, 8, 11, 13, 15, 21 & 28 (given 1 time) November 2011 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Pink Bismuth – PRN – 11/5 (given 1 time) • Zyprexa 5mg – PRN – 11/6 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the		

	following PRN medication: • Pink Bismuth – PRN – 11/5 (given 1 time) • Zyprexa 5mg – PRN – 11/6 (given 1 time) Individual #8 September 2011 No evidence of documented Signs/Symptoms was found for the following PRN medication: • Lactaid – PRN – 9/1, 8, 9, 15, 19, 20, 22, 25 & 28 (given 1 time) & 9/2 (given 2 times) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Lactaid – PRN – 9/1, 8, 9, 15, 19, 20, 22, 25 & 28 (given 1 time) & 9/2 (given 2 times) November 2011 No evidence of documented Signs/Symptoms was found for the following PRN medication: • Robutussin DM – PRN – 11/2 (given 1 time) Individual #9 September 2011 No evidence of documented Signs/Symptoms was found for the following PRN medication: • Acetaminophen 325mg – PRN – 9/23 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 325mg – PRN – 9/23 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication:		

	• Acetaminophen 325mg – PRN – 9/23 (given 1 time) Individual #10 October 2011 No evidence of documented Signs/Symptoms was found for the following PRN medication: • Ibuprofen 800mg – PRN – 10/18,19, 20, 23 & 25 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 800mg – PRN – 10/18,19, 20, 23 & 25 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 800mg – PRN – 10/18,19, 20, 23 & 25 (given 1 time) Individual #12 September 2011 No evidence of documented Signs/Symptoms was found for the following PRN medication: • Acetaminophen 325mg – PRN – 9/8 & 26 (given 1 time) • Pink Bismuth – PRN – 9/26 (given 1 time) • Guiatuss (Robitussin) – PRN – 9/12,15 , 22, 23, 28 & 30 (given 1 time); 9/16,17 & 19 (given 4 times) • Lorazepam 1mg – PRN – 9/8 (given 1 time) • Lactaid – PRN – 9/1, 13, 29 & 30 (given 1 time)		

	No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 325mg – PRN – 9/8 & 26 (given 1 time) • Pink Bismuth – PRN – 9/26 (given 1 time) • Guiatuss (Robitussin) – PRN – 9/12,15 , 22, 23, 28 & 30 (given 1 time); 9/16,17 & 19 (given 4 times) • Lorazepam 1mg – PRN – 9/8 (given 1 time) • Lactaid – PRN – 9/1, 13, 29 & 30 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 325mg – PRN – 9/8 & 26 (given 1 time) • Pink Bismuth – PRN – 9/26 (given 1 time) • Guiatuss (Robitussin) – PRN – 9/12,15 , 22, & 23 (given 1 time); 9/16,17 & 19 (given 4 times) • Lorazepam 1mg – PRN – 9/8 (given 1 time) October 2011 No evidence of documented Signs/Symptoms was found for the following PRN medication: • Hydrocortisone 2.5% – PRN – 10/28 & 31 (given 1 time) & 10/29 & 30 (given 2 times) • Azithromycin 250mg – PRN – 10/28, 29, 30		

	& 31 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Lactaid – PRN – 10/9 & 14 (given 1 time) • Hydrocortisone 2.5% – PRN – 10/28 & 31 (given 1 time) & 10/29 & 30 (given 2 times) • Azithromycin 250mg – PRN – 10/28, 29, 30 & 31 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Lactaid – PRN – 10/9 & 14 (given 1 time) November 2011 No evidence of documented Signs/Symptoms was found for the following PRN medication: • Lorazepam 1mg – PRN – 11/9 (given 1 time) • Lactaid – PRN – 11/4 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Lorazepam 1mg – PRN – 11/9 (given 1 time) • Lactaid – PRN – 11/4 (given 1 time)		

Tag # 1A09.2 Medication Delivery - PRN Nurse Approval	*CoP Level Deficiency*		
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. **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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to maintain documentation of PRN usage as required by standard for 9 of 12 Individuals. Individual #1 September 2011 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Azithromycin 250mg – PRN – 9/15, 16, 17, 18 & 19 (given 1 time) Individual #2 September 2011 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Penicillin VK 500mg – PRN – 9/2 & 6 (given 3 times); 9/3, 4 & 5 (given 4 times) • Ciclopirox 0.77% - PRN – 9/10, 11, 12, 13 & 14 (given 1 time) & 9/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times) Individual #3 September 2011 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication:	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. Enter your Quality Assurance/Quality Improvement processes *below* the line.	

(including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual. 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:**	• Ativan 0.5mg – PRN – 9/16 (given 1 time) & 9/17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times) • Acetaminophen 325mg – PRN – 9/10 & 11 (given 1 time) • Triple Antibiotic Ointment – PRN – 9/11 (given 1 time) Individual #6 September No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Ibuprofen 200mg – PRN – 9/29 (given 1 time) Individual #7 September 2011 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Zyprexa 5mg – PRN – 9/1, 6, 8, 11, 13, 15, 21 & 28 (given 1 time) November 2011 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Pink Bismuth – PRN – 11/5 (given 1 time) • Zyprexa 5mg – PRN – 11/6 (given 1 time) Individual #8 September 2011		

Medication Assessment and Delivery Procedure Eff Date: November 1, 2006 C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications). a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.). **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;	No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Lactaid – PRN – 9/1, 8, 9, 15, 19, 20, 22, 25 & 28 (given 1 time) & 9/2 (given 2 times) Individual #9 September 2011 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Acetaminophen 325mg – PRN – 9/23 (given 1 time) Individual #10 October 2011 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Ibuprofen 800mg – PRN – 10/18,19, 20, 23 & 25 (given 1 time) Individual #12 September 2011 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Acetaminophen 325mg – PRN – 9/8 & 26 (given 1 time) • Pink Bismuth – PRN – 9/26 (given 1 time) • Guiatuss (Robitussin) – PRN – 9/12,15 , 22, & 23 (given 1 time); 9/16,17 & 19 (given 4 times)		

(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.	• Lorazepam 1mg – PRN – 9/8 (given 1 time) • Lactaid – PRN – 9/1, 13, 29 & 30 (given 1 time) October 2011 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Hydrocortisone 2.5% – PRN – 10/28 & 31 (given 1 time) & 10/29 & 30 (given 2 times) • Azithromycin 250mg – PRN – 10/28, 29, 30 & 31 (given 1 time) November 2011 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Lorazepam 1mg – PRN – 11/9 (given 1 time) • Lactaid – PRN – 11/4 (given 1 time)		

Tag # 1A15.2 & 5I09 - Healthcare Documentation	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. **Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities** (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse.	Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 4 of 12 individuals. The following were not found, incomplete and/or not current: • **Special Health Care Needs:** • *Nutritional Plan* ◦ Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ◦ Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ◦ Individual #11 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • **Health Care Plans** • *BMI* ◦ Individual #2 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • **Crisis Plans/Medical Emergency Response Plans** • *Constipation* ◦ Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request. (c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first. (d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy). (e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as *subjective* information including the individual complaints, signs and symptoms noted by staff, family members or other team members; *objective* information including vital signs, physical	• *Falls* ◦ Individual #2 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.		

examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants. **(2) Health related plans** (a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional. (b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan. (c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. (d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings. (3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended): (a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved			

through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition. (b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal. (c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan. (d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions. (e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings. (f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.			

(g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author. (h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed. **(4) General Nursing Documentation** (a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person. (b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **B**. **IDT Coordination** (1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and (2) Coordinate with the IDT to ensure that			

each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan. **Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010** F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911. 5. Emergency contacts with phone numbers. 6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.			

Tag # 1A27 Incident Mgt Late & Failure to Report	Standard Level Deficiency		
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	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 9 of 17 individuals. Individual #1 • Incident date 4/21/2011. Allegation was Abuse. Incident report was received 6/8/2011. Late Reporting. IMB Late & Failure Report indicated incident of Abuse and Neglect was "Confirmed." Individual #5 • Incident date 6/19/2011. Allegation was Neglect. Incident report was received 6/22/2011. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." • Incident date 8/6/2011. Allegation was Neglect. Incident report was received 8/11/2011. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #8 • Incident date 11/13/2010. Allegation was Neglect. Incident report was received 11/17/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #12 • Incident date 8/2/2011. Allegation was	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

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.	Neglect. Incident report was received 8/9/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #13 • Incident date 2/8/2011. Allegation was Abuse, Neglect, Emergency Services, Law Enforcement Involvement. Incident report was received 2/10/2011. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #14 • Incident date 6/7/2011. Allegation was Abuse, Exploitation & Law Enforcement Involvement. Incident report was received 6/8/2011. Failure to Report. IMB Late & Failure Report indicated incident of Neglect & Exploitation was "Confirmed." Individual #15 • Incident date 6/18/2011. Allegation was Abuse. Incident report was received 6/22/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #16 • Incident date 6/19/2011. Allegation was Abuse. Incident report was received 6/23/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #17 • Incident date 6/25/2011. Allegation was Neglect. Incident report was received 7/1/2011. Failure to Report. IMB Late &		

	Failure Report indicated incident of Neglect was “Confirmed.”		

Tag # 1A27.2 Duty to Report - IRs Filed During On-Site and/or IR's Not Reported by Provider	Standard Level Deficiency		
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	Based on record review, 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 3 of 12 Individuals. During the on-site survey Nov 14 – 17, 2011, surveyors found evidence of 4 internal agency incident reports, which had not been reported to DHI and/or APS/CYFD, as required by regulation. The following internal incidents were reported as a result of the on-site survey: Individual #1 • Incident date 10/16/2010 (7:30 AM). Type of incident identified was exploitation. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 11/17/2011 by the Agency. • Incident date 5/9/2011 (6:40 PM). Type of incident identified was neglect. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 11/17/2011 by the Agency. Individual #5 • Incident date 1/13/2011 (4 PM) Type of incident identified was exploitation. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 11/17/2011 by the agency.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

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. **(2) Division Incident Report Form and Notification by Community Based Service Providers:** The community based service provider shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide. The community based service provider shall ensure all incident report forms alleging abuse, neglect or misappropriation of consumer property submitted by a reporter with direct knowledge of an incident are completed on the division's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The community based service provider shall ensure that the reporter with the most direct knowledge of the incident prepares the incident report form.	Individual #12 • Incident date 5/14/2011 (11 AM) Type of incident identified was abuse. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 11/17/2011 by the agency.		

Tag # 1A29 Complaints / Grievances - Acknowledgement	Standard Level Deficiency		
NMAC 7.26.3.6 A These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's complaint or grievance procedure	Based on record review, the Agency failed to provide documentation the complaint procedure had been made available to individuals or their legal guardians for 2 of 12 individuals. • Grievance/Complaint Procedure Acknowledgement (#7 & 12)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Tag # 1A31 Client Rights/Human Rights	*CoP Level Deficiency*		
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] **Long Term Services Division** **Policy Title: Human Rights Committee**	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to ensure the rights of Individuals were not restricted or limited for 7 of 12 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. No documentation was found regarding needed Human Rights Approval for the following: • Physical Restraint (Monitor sensor, baby monitor, sharps locked, food storage locked) - (Individual #1) • Psychotropic Medications (Ativan) to control behaviors. No evidence found of Human Rights Committee approval. (Individual #3) • Physical Restraint (Removal of door, window alarms, locked windows & line of sight) - (Individual #4) • Physical Restraint (CPI) - (Individual #5) • Physical Restraint (per Positive Behavior Crisis Plan) - (Individual #7 & 9) • Physical Restraint (Bedroom door sensor) - (Individual #8)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Requirements Eff Date: March 1, 2003 **IV. POLICY STATEMENT -** Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans. Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies: • Aversive Intervention Prohibitions • Psychotropic Medications Use • Behavioral Support Service Provision. A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up. **A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS** Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval. 2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly. 3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least			

five years from the completion of each individual's Individual Service Plan. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:** **Medication Assessment and Delivery** **Procedure Eff Date: November 1, 2006** **B. 1. e.** If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).			

Tag # 1A33 Board of Pharmacy - Med Storage	Standard Level Deficiency		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **E. Medication Storage:** 1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee. 2. Drugs to be taken by mouth will be separate from all other dosage forms. 3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature. 4. Separate compartments are required for each resident's medication. 5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day. 6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist. **8. References** A. Adequate drug references shall be available for facility staff **H. Controlled Substances (Perpetual Count Requirement)** 1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled	Based on observation, the Agency failed to ensure proper storage of medication for 1 of 12 individuals. Observation included: Individual #9 • Ciclopirox 0.77% cream is a topical medication and was not kept separate from oral dosage forms of other medications.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

substance, indicating the following information: a. date b. time administered c. name of patient d. dose e. practitioner's name f. signature of person administering or assisting with the administration the dose g. balance of controlled substance remaining.			

Tag #1A39 Assistive Technology & Adaptive Equipment	Standard Level Deficiency		
CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION **F. Sanitation:** (1) Equipment and utensils shall be kept clean and in good repair; and **7.26.5.13 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - ASSESSMENTS:** **7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS:** Each ISP shall contain: **F. Assistive technology:** Necessary support mechanisms and devices, including the rationale for the use of assistive technology or adaptive equipment when a need has been identified shall be documented in the ISP. The rationale shall include the environments and situations in which assistive technology is used. Selection of assistive technology shall support the individual's independence and functional capabilities in as non-intrusive a fashion as possible. **CHAPTER 5 VI. SCOPE OF SUPPORTED EMPLOYMENT SERVICES** (7) Facilitating job accommodations and use of assistive technology, including the use of communication devices; **CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS** **D. Provider Agency Requirements**	Based on interview the Agency failed to ensure the necessary support mechanisms and devices, including the rationale for the use of assistive technology or adaptive equipment was in place for 1 of 12 Individuals. Review of documents indicated eyeglasses were required to be used by the Individual. **During interview DSP were asked if the Individual had any assistive device or adaptive equipment and was it in functioning order.** • DSP #104 stated the following, "Doesn't have glasses," "Can't afford them." (Individual #5)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. Enter your Quality Assurance/Quality Improvement processes *below* the line.	

(6) Qualification and Competencies for Supported Employment Staff (includes intensive): Qualifications and competencies for staff providing job coaching/consultation services shall, at a minimum, are able to: **CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS** **F. Community Access Services Provider Agency Staff Qualifications and Competencies** (1) Qualifications and Competencies for Community Access Coaches. The Community Access Coach shall, at a minimum, demonstrate the ability to: (q) Communicate effectively with the individual including communication through the use of adaptive equipment and use of a communication dictionary when the individual uses these modes of communication; (j) Communicate effectively with the individual including communication through the use of adaptive equipment as well as the individual's Communication Dictionary, if applicable, at the work site; **CHAPTER 6. II. SCOPE OF COMMUNITY LIVING SERVICES**. **A**. The scope of Community Living Services includes, but is not limited the following as identified by the IDT: (8) Implementation of the ISP, Therapy, Meal-time, Positive Behavioral Supports, Health Care, and Crisis Prevention/Interventions Plans, if applicable;			

(9) Assistance in developing health maintenance supports, as well as monitoring the effectiveness of such supports; (12) Assist the individual as needed, in coordination with the designated healthcare coordinator and others on the IDT, with access to medical, dental, therapy, nutritional, behavioral and nursing practitioners and in the timely implementation of healthcare orders, monitoring and recording of therapeutic plans or activities as prescribed, to include: health care and crisis prevention/ intervention plans; **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **H. Community Living Services Provider Agency Staffing Requirements** **(**1) Community Living Service Staff Qualifications and Competencies: Individuals working as direct support staff and supervisors for Community Living Service Provider Agencies shall demonstrate the following: (b) The ability to assist the individual to meet his or her physical (e.g., health, grooming, toileting, eating) and personal management needs, by teaching skills, providing supports, and building on individual strengths and capabilities; **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:			

(5) Kitchen area shall: (b) Arrangements will be made, in consultation with the IDT for environmental accommodations and assistive technology devices specific to the needs of the individual(s); and			

Tag # 6L13 Community Living Healthcare Reqts.	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a)Provision of health care oversight	Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 7 of 12 individuals receiving Community Living Services. The following was not found, incomplete and/or not current: • **Annual Physical** (#10) • **Dental Exam** ◦ Individual #3 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #11 - As indicated by collateral documentation reviewed, exam was completed on 11/3/2009. Follow-up was to be completed in 1 year. No evidence of follow-up found. • **Vision Exam** ◦ Individual #3 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #8 - As indicated by collateral documentation reviewed, exam was completed on 4/20/2009. Follow-up was to be completed in 1 year. No evidence of follow-up found. ◦ Individual #9 - As indicated by collateral documentation reviewed, exam was completed on 4/7/2009. Individual was to	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. Enter your Quality Assurance/Quality Improvement processes *be*l*ow* the line.	

consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse. (c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition. (4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT. (5) That the physical property and grounds are free of hazards to the individual's health and safety. (6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following: (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment,	return in 24 months. No evidence of follow-up found. • **Auditory Exam** ◦ Individual #7 - As indicated by collateral documentation reviewed, exam was completed on 3/9/2011. Documentation stated, "Reevaluate hearing following wax removal." No evidence of re-evaluation found. • **Pap Smear Exam** ◦ Individual #6 - As indicated by collateral documentation reviewed, an exam was recommended on 4/5/2011. No evidence of exam results was found.		

visits to specialists, changes in medication or daily routine). **NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.			

Tag # 6L25 Residential Health & Safety (Supported Living & Family Living)	*CoP Level Deficiency*		
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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 7 of 7 Supported Living residences. The following items were not found, not functioning or incomplete: **Supported Living Requirements:** • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#11) • Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#7 & 12) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#2, 6, 8, 9 & 11) • 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, 3, 4, 5, 6, 8, 9, 10 & 11)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. Enter your Quality Assurance/Quality Improvement processes *below* the line.	

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.	*Note - The following Individuals share a residence: #2, 6 & 8; #5 & 10; #1 & 3; #7 & 12.*		

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Financial Accountability – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver*.			
Tag # 5I44 Adult Habilitation Reimbursement	**Standard Level Deficiency**		
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**	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 6 of 12 individuals. Individual #1 July 2011 • The Agency billed 92 units of Adult Habilitation (T2021) from 7/11/2011 through 7/15/2011. Documentation received accounted for 88 units. • The Agency billed 66 units of Adult Habilitation (T2021) from 7/18/2011 through 7/21/2011. Documentation received accounted for 58 units. August 2011 • The Agency billed 17 units of Adult Habilitation (T2021) from 8/8/2011 through 8/12/2011. Documentation received accounted for 16 units. • The Agency billed 86 units of Adult Habilitation (T2021) from 8/15/2011 through 8/19/2011. Documentation received accounted for 78 units. Individual #2 July 2011 • The Agency billed 57 units of Adult	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

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** **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	Habilitation (T2021) from 7/25/2011 through 7/29/2011. Documentation received accounted for 42 units. Individual #3 July 2011 • The Agency billed 18 units of Adult Habilitation (T2021) from 7/4/2011 through 7/8/2011. Documentation received accounted for 13 units. • The Agency billed 74 units of Adult Habilitation (T2021) from 7/11/2011 through 7/15/2011. Documentation received accounted for 72 units. • The Agency billed 40 units of Adult Habilitation (T2021) from 7/18/2011 through 7/22/2011. Documentation received accounted for 39 units. August 2011 • The Agency billed 12 units of Adult Habilitation (T2021) from 8/15/2011 through 8/19/2011. Documentation received accounted for 11 units. • The Agency billed 12 units of Adult Habilitation (T2021) from 8/22/2011 through 8/26/2011. Documentation received accounted for 8 units. Individual #8 August 2011 • The Agency billed 120 units of Adult Habilitation (T2021) from 8/29/2011 through 9/3/2011. Documentation received accounted for 104 units.		

	September 2011 • The Agency billed 112 units of Adult Habilitation (T2021) from 9/19/2011 through 9/23/2011. Documentation received accounted for 101 units. Individual #9 August 2011 • The Agency billed 120 units of Adult Habilitation (T2021) from 8/29/2011 through 9/2/2011. Documentation received accounted for 116 units. Individual #12 July 2011 • The Agency billed 118 units of Adult Habilitation (T2021) from 7/4/2011 through 7/8/2011. Documentation received accounted for 96 units. • The Agency billed 120 units of Adult Habilitation (T2021) from 7/11/2011 through 7/15/2011. Documentation received accounted for 90 units. • The Agency billed 120 units of Adult Habilitation (T2021) from 7/18/2011 through 7/22/2011. Documentation received accounted for 99 units. • The Agency billed 112 units of Adult Habilitation (T2021) from 7/25/2011 through 7/29/2011. Documentation received accounted for 86 units. August 2011 • The Agency billed 118 units of Adult Habilitation (T2021) from 8/1/2011 through 8/5/2011. Documentation received		

	accounted for 110 units. • The Agency billed 120 units of Adult Habilitation (T2021) from 8/8/2011 through 8/12/2011. Documentation received accounted for 110 units. • The Agency billed 118 units of Adult Habilitation (T2021) from 8/15/2011 through 8/19/2011. Documentation received accounted for 112 units.		

Date: February 14, 2012

To: Patsy Tarin, Finance Manager/Team Leader
Provider: Campo Behavioral Health
Address: 424 N. Mesilla Street
State/Zip: Las Cruces, NM 88005
E-mail Address: PTarin@campobh.com

Region: Southwest
Survey Date: November 14-17, 2011
Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Ms. Tarin,

Your request for a Reconsideration of Findings was received on February 2, 2012. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A09
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, deficiencies noted in tag 1A09 for medications to be administered Individual #1 for 9/20/11 and 10/17-19, 2011 will be removed. Other medication errors cited were not eligible for reconsideration as no supporting evidence was submitted.

Regarding Tag # 1A09.1
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, deficiencies noted in tag 1A09.1 for medications to be administered on a PRN basis will be removed. Other medication errors cited were not eligible for reconsideration as no supporting evidence was submitted. (see below for the detailed list of citations to be removed).

Individual #1
September 2011
No evidence of documented Signs/Symptoms were found for the following PRN medication:
- *Azithromycin 250mg – PRN – 9/15, 16, 17, 18 & 19 (given 1 time)*

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:
- *Azithromycin 250mg – PRN – 9/15, 16, 17, 18 & 19 (given 1 time)*

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

- *Azithromycin 250mg – PRN – 9/15, 16, 17, 18 & 19 (given 1 time)*
- *Sore Throat Spray – PRN – 9/7 (given 1 time)*

Individual #2
September 2011
No evidence of documented Signs/Symptoms were found for the following PRN medication:
- *Penicillin VK 500mg – PRN – 9/2 & 6 (given 3 times); 9/3, 4 & 5 (given 4 times)*

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:
- *Penicillin VK 500mg – PRN – 9/2 & 6 (given 3 times); 9/3, 4 & 5 (given 4 times)*

No Time of Administration was noted on the Medication Administration Record for the following PRN medication:
- *Penicillin VK 500mg – PRN – 9/2 & 6 (given 3 times); 9/3, 4 & 5 (given 4 times)*

Individual #3
September 2011
No evidence of documented Signs/Symptoms were found for the following PRN medication:
- *Ativan 0.5mg – PRN – 9/16 (given 1 time) & 9/17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times)*

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:
- *Ativan 0.5mg – PRN – 9/16 (given 1 time) & 9/17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times)*

Regarding Tag # 1A09.2
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, deficiencies noted in tag 1A09.1 for medications to be administered on a PRN basis will be removed. Other medication errors cited and disputed were requested during the on-site survey and not received. (see below for the detailed list of citations to be removed).

Individual #1
September 2011
No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication:
- *Azithromycin 250mg – PRN – 9/15, 16, 17, 18 & 19 (given 1 time)*

Individual #2
September 2011
No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication:
- *Penicillin VK 500mg – PRN – 9/2 & 6 (given 3 times); 9/3, 4 & 5 (given 4 times)*
- *Ciclopirox 0.77% - PRN – 9/10, 11, 12, 13 & 14 (given 1 time) & 9/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times)*

Individual #3
September 2011
No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication:
- *Ativan 0.5mg – PRN – 9/16 (given 1 time) & 9/17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times)*

Regarding Tag # 1A37
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the document request form specific to training, the documents needed to demonstrate trainings had occurred were requested from and signed by Randy De La O on 11/16/11 and not received prior to the end of the survey. The remaining citations noted in tag 1A37 were not disputed.

Regarding Tag # 6L14
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied the Residential Interview and Case File Review Tool, the documents were requested from and signed by your home staff and not received prior to the end of the survey. The remaining citations noted in tag 6L14 were not disputed.

Regarding Tag # 6L13
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied the missing evaluations were at the order of a physician and not considered optional. The remaining citations noted in tag 6L13 were not disputed.

Regarding Tag # 1A15.2/5I09
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, deficiencies noted in tag 1A15.2/5I09 will stand due to the lack of evidence supplied to support your request for an IRF. The remaining citations noted in tag 1A15.2/5I09 were not disputed.

This concludes the Informal Reconsideration of Finding process. The IRF process is separate and apart from the Informal Dispute Resolution process or the Medicaid Fair Hearing process when DOH sanctions are imposed on a provider.

Thank you.
Respectfully,

Scott Good
Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair

Date: April 20, 2012

To: Ms. Patsy Tarin, Team Leader

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

CC (email): Dr. Daniel Brandt, Owner
DBrandt@campobh.com

Region: Southwest
Survey Date: November 14 - 17, 2011
Program Surveyed: Developmental Disabilities Waiver
Services Surveyed: Living Supports (Supported Living) & Inclusion Supports (Adult Habilitation)
Survey Type: Routine

Dear Ms. Tarin and Dr. Brandt:

The Division of Health Improvement Quality Management Bureau received, reviewed and approved the documents you submitted for your Plan of Correction. Your Plan of Correction is not closed.

Your Plan of Correction will be considered for closure when a Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections.

The Quality Management Bureau will be conducting an unannounced verification survey to ensure survey deficiencies have been corrected, and that systemic Quality Improvement and Quality Assurance processes have been effective at sustaining corrections.

If the Verification survey determines survey deficiencies have been corrected and corrective measures have effectively maintained compliance with DDW Standards, your Plan of Correction will be considered for closure.

If the Verification survey identifies Repeat deficiencies, your case will be referred to the Internal Review Committee for discussion of possible monetary fines and/or other sanctions.

Thank you for your cooperation with the Plan of Correction process, and for the work you and your team perform.

Sincerely,

George Perrault, MBA
Plan of Correction Coordinator

Cc: DHI
DDSD