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Secretary

DEPARTMENT OF

*Building a Healthy New Mexico!*

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Deputy Secretary

**Karen Armitage, MD**  
Chief Medical Officer

Date: December 15, 2008

To: Mark Schinnerer, Executive Director  
Provider: CARC, Inc.  
Address: 902 W. Cherry Lane  
State/Zip: Carlsbad, NM 88220

CC: Jay Jenkins, Board Chair  
Address: P.O. Box 1233  
State/Zip: Carlsbad, NM 88221

E-mail Address: tammyhalpain@hotmail.com

Region: Southeast  
Survey Date: October 14 – 16, 2008  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Community Living (Supported Living & Independent Living) & Community Inclusion (Adult Habilitation, Supported Employment & Community Access)  
Survey Type: Routine  
Team Leader: Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Team Members: Crystal Lopez, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Cynthia Neilsen, RN, MSN, Healthcare Surveyor & Florie Alire, RN, Healthcare Surveyor  
Survey #: Q09.02.D2156.SE.001.RTN.01

Dear Mr. Schinnerer,

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

**Quality Management Approval Rating:**

The Division of Health Improvement is granting your agency a “STANDARD” certification for basic compliance with DDSD Standards and regulations.

**Plan of Correction:**

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

1. Quality Management Bureau, Attention: Plan of Correction Coordinator  
5301 Central Ave. NE Suite 900 Albuquerque, NM 87108
2. Developmental Disabilities Supports Division Regional Office for region of service surveyed.

Upon notification from QMB that your Plan of Correction has been approved, you must implement all remedies and corrective actions within 45 working days. If your plan of correction is denied, you must resubmit a revised plan ASAP for approval. All remedies must still be completed within 45 working days of the original submission.

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

**Request for Informal Reconsideration of Findings (IRF):**

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

QMB Deputy Bureau Chief  
5301 Central Ave NE Suite #900  
Albuquerque, NM 87108  
Attention: IRF request

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

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

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

Please call the Team Leader at 505-690-4693, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,



Deb Russell, BS  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: October 14, 2008

Present: **CARC, Inc.**  
Tammy Halpain, Social Services Director

**DOH/DHI/QMB**  
Deb Russell, BS, Team Lead/Healthcare Surveyor  
Crystal Lopez-Beck, BA, Healthcare Surveyor

Exit Conference Date: October 16, 2008

Present: **CARC, Inc**  
Tammy Halpain, Social Services Director  
Bob Barnes, Assistant Social Services Director  
Manuel Jimenez, Community Inclusion Director  
Homer Freeman, Work Services Director  
Nancy Bradford, Human Resources Director  
Dora Leyva, Residential Services Director  
Tina Reese, Community Living Manager  
Mark Schinnerer, Executive Director  
Sarah Andrews, Executive Assistant

**DOH/DHI/QMB**  
Deb Russell, BS, Team Lead/Healthcare Surveyor  
Crystal Lopez-Beck, BA, Healthcare Surveyor  
Cynthia Neilsen, RN, MSN, Healthcare Surveyor  
Florie Alire, RN, Healthcare Surveyor

<b>Homes Visited</b>	<b>Number:</b>	<b>2</b>
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	8 4 - Supported Living 3 - Independent Living 8 - Adult Habilitation 5 - Supported Employment 4 - Community Access
Persons Served Interviewed	Number:	4
Persons Served Observed	Number:	4 (Surveyors were unable to understand 2 individuals and 2 other individuals were not available during the on-site visit)
Records Reviewed (Persons Served)	Number:	8
Administrative Files Reviewed		<ul style="list-style-type: none"><li>• Billing Records</li><li>• Medical Records</li><li>• Incident Management Records</li><li>• Personnel Files</li><li>• Training Records</li><li>• Agency Policy and Procedure</li><li>• Caregiver Criminal History Screening Records</li></ul>

- Employee Abuse Registry
- Human Rights Notes and/or Meeting Minutes
- Nursing personnel files
- Evacuation Drills
- Quality Improvement/Quality Assurance Plan

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

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8624.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency (“Responsible Party”), and by WHEN (“Date Due”).
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues to prevent the Deficiency from reoccurring, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency’s Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to George.Perrault@state.nm.us, by fax (505-841-5815), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been “Approved” or “Denied”.
- Whether your POC is “Approved” or “Denied”, you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is “Denied” it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- The following Deficiencies must be corrected within the deadlines below (after receipt of your Survey Report):
  - CCHS and EAR: 10 working days
  - Medication errors: 10 working days
  - IMS system/training: 20 working days
  - ISP related documentation: 30 working days
  - DDSD Training 45 working days
- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8624 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.
- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by case basis.

- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual #s.
- Do not submit original documents, copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

**QMB Scope and Severity Matrix of survey results**

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

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

Scope and Severity Definitions:

Key to Scope scale:

Isolated:

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

Pattern:

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

Widespread:

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

Key to Severity scale:

Low Impact Severity: (Blue)

Low level findings have no or minimal potential for harm to an individual. Providers that have no findings above a "C" level may receive a "Quality" Certification approval rating from QMB.

Medium Impact Severity: (Tan)

Medium level findings have a potential for harm to an individual. Providers that have no findings above a "F" level and/or no more than two F level findings and no F level Conditions of Participation may receive a "Merit" Certification approval rating from QMB.

High Impact Severity: (Green or Yellow)

High level findings are when harm to an individual has occurred. Providers that have no findings above "I" level may only receive a "Standard" Approval rating from QMB and will be referred to the IRC.

High Impact Severity: (Yellow)

"J, K, and L" Level findings:

This is a finding of Immediate Jeopardy. If a provider is found to have "I" level findings or higher, with an outcome of Immediate Jeopardy, including repeat findings or Conditions of Participation they will be referred to the Internal Review Committee.



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

### **Introduction:**

Throughout the process, surveyors are openly communicating with providers. Open communication means that surveyors have clarified issues and/or requested missing information before completing the review. Regardless, there may still be instances where the provider disagrees with a specific finding.

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

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

### **The following limitations apply to the IRF process:**

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

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

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

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

### **Administrative Review Process:**

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

**Regarding IRC Sanctions:**

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

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

**Agency:** CARC, Inc. - Southeast Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Living (Supported Living & Independent Living) & Community Inclusion (Community Access, Supported Employment & Adult Habilitation)  
**Monitoring Type:** Routine  
**Date of Survey:** October 14 – 16, 2008

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<p><b>Tag # 1A08 Agency Case File</b></p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>D. Provider Agency Case File for the Individual:</b> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</p> <p>(1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;</p>	<p><b>Scope and Severity Rating: B</b></p> <p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 3 of 8 individuals.</p> <p>Review of the Agency individual case files revealed the following items were missing, incomplete, and/or not current:</p> <ul style="list-style-type: none"> <li>• Annual ISP (#4 &amp; 5)</li> <li>• ISP Signature Page (#4 &amp; 5)</li> <li>• Addendum A (#4 &amp; 5)</li> <li>• Individual Specific Training (Addendum B) (#4 &amp; 5)</li> <li>• Positive Behavioral Plan (#5)</li> <li>• Speech Therapy Plan (#1)</li> </ul>		

<ul style="list-style-type: none"> <li>(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);</li> <li>(3) Progress notes and other service delivery documentation;</li> <li>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</li> <li>(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;</li> <li>(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</li> <li>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</li> <li>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: <ul style="list-style-type: none"> <li>(a) Complete file for the past 12 months;</li> <li>(b) ISP and quarterly reports from the current and prior ISP year;</li> <li>(c) Intake information from original admission to services; and</li> <li>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</li> </ul> </li> </ul>			
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Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: A		
<p><b>Developmental Disabilities (DD) Waiver Service Standards Chapter 1. III. E. (1 - 4)</b>  <b>CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:</b> Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p><b>(1) Documentation of nursing assessment activities</b></p> <p>(a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training:</p> <ul style="list-style-type: none"> <li>(i) Community living services provider agency;</li> <li>(ii) Private duty nursing provider agency;</li> <li>(iii) Adult habilitation provider agency;</li> <li>(iv) Community access provider agency; and</li> <li>(v) Supported employment provider agency.</li> </ul> <p>(b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 3 of 8 individuals.</p> <p>The following were not found or not current:</p> <ul style="list-style-type: none"> <li>• Crisis Plans <ul style="list-style-type: none"> <li>• Aspiration (#3)</li> <li>• Seizures (#8)</li> <li>• Respiratory (#6)</li> </ul> </li> <li>• Health Care Plans <ul style="list-style-type: none"> <li>• Potential for Skin Breakdown (#3)</li> <li>• Aspiration (#3)</li> <li>• Tardive Dyskensia (#3)</li> </ul> </li> </ul>		

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 DDS 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 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.

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:</b> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p><b>C. Orientation and Training Requirements:</b> Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</p> <p>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 20 of 41 Direct Service Personnel.</p> <p>Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> <li>• Person-Centered Planning (1-Day) (DSP #27, 40 &amp; 42)</li> <li>• First Aid (DSP #55 &amp; 60)</li> <li>• CPR (DSP #36, 45, 55, 56 &amp; 57)</li> <li>• Level 1 Health (DSP #33, 34, 35, 37, 45 &amp; 51)</li> <li>• Teaching &amp; Support Strategies (DSP #33, 35 &amp; 41)</li> <li>• Positive Behavior Supports Strategies (DSP #23, 30, 33, 34, 35, 37, 38, 45, 48 &amp; 50)</li> <li>• Participatory Communication &amp; Choice Making (DSP #41)</li> </ul>		

Tag # 1A22 Staff Competence	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p><b>F. Qualifications for Direct Service Personnel:</b> The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</p> <ol style="list-style-type: none"> <li>(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;</li> <li>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</li> <li>(3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual;</li> <li>(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</li> </ol>	<p>Based on interview, the Agency failed to ensure that training competencies were met for 2 of 8 Direct Service Personnel.</p> <p>When DSP were asked if they received training on the Individuals ISP, the following was reported:</p> <ul style="list-style-type: none"> <li>• DSP #52 stated, "I have had no training."</li> </ul> <p>When DSP were asked if they received training on the Individuals Health Care Plans, the following was reported:</p> <ul style="list-style-type: none"> <li>• DSP #23 stated, "No." Per record review Individual #6 has Health Care Plans for Incontinence, Constipation &amp; Oxygen.</li> </ul>		

<p>Individuals with Developmental Disabilities; and</p> <p>(5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support.</p> <p>(6) Report required personnel training status to the DDS Statewide Training Database as specified in DDS policies as related to training requirements as follows:</p> <p>(a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDS Statewide Training Database within the first ninety (90) calendar days of providing services;</p> <p>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</p> <p>(c) Quarterly personnel update reports sent to DDS Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p>			
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Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D		
<p><b>NMAC 7.1.9.9</b>  <b>A. Prohibition on Employment:</b> 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.</p> <p><b>NMAC 7.1.9.11</b>  <b>DISQUALIFYING CONVICTIONS.</b> The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:  <b>A.</b> homicide;  <b>B.</b> trafficking, or trafficking in controlled substances;  <b>C.</b> kidnapping, false imprisonment, aggravated assault or aggravated battery;  <b>D.</b> rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;  <b>E.</b> crimes involving adult abuse, neglect or financial exploitation;  <b>F.</b> crimes involving child abuse or neglect;  <b>G.</b> crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or  <b>H.</b> an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p> <p>Chapter 1.IV. General Provider Requirements.  D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee’s qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.</p>	<p>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 1 of 46 Agency Personnel.</p> <ul style="list-style-type: none"> <li>• #38 – Date of hire 9/12/08</li> </ul>		

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: E		
<p><b>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b></p> <p><b>A. General:</b> All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p><b>D. Training Documentation:</b> All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</p>	<p>Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 16 of 46 Agency Personnel.</p> <ul style="list-style-type: none"> <li>Incident Management (Abuse, Neglect &amp; Exploitation) (#33, 34, 35, 36, 37, 38, 39, 44, 48, 54, 55, 56, 57, 58, 60 &amp; 61)</li> </ul>		

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: E		
<p><b>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b></p> <p><b>A. General:</b> All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p><b>E. Consumer and Guardian Orientation Packet:</b> Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.</p>	<p>Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of abuse, neglect or exploitation for 2 of 8 individuals.</p> <ul style="list-style-type: none"> <li>• Parent/Guardian Incident Management (Abuse, Neglect &amp; Exploitation) Training (#5 &amp; 8)</li> </ul>		

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: E		
<p><b>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b></p> <p><b>A. General:</b> All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p><b>F. Posting of Incident Management Information Poster:</b> All licensed health care facilities and community based service providers shall post two (2) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. All licensed health care facilities and community based service providers operating sixty (60) or more beds shall post three (3) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. The posters shall be posted where employees report each day and from which the employees operate to carry out their activities. Each licensed health care facility or community based service provider shall take steps to insure that the notices are not altered, defaced, removed, or covered by other material. [7.1.13.10 NMAC - N, 02/28/06]</p>	<p>Based on observation, the Agency failed to post two (2) or more Incident Management Information posters in a prominent public location for the following locations:</p> <p>Residence of:</p> <ul style="list-style-type: none"> <li>• Individual #1, 5 &amp; 7 (Note: #1 &amp; 5 - The Incident Management Information Poster found in the home did not contain the Adult Protective Services contact numbers and internet information.)</li> </ul>		



Tag # 1A29 Complaints / Grievances	Scope and Severity Rating: B		
<p><b>NMAC 7.26.3.6</b>  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].</p> <p><b>NMAC 7.26.3.13 Client Complaint Procedure Available.</b> 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]</p> <p><b>NMAC 7.26.4.13 Complaint Process:</b>  <b>A. (2).</b> The service provider's complaint or grievance procedure shall provide, at a minimum, that: <b>(a)</b> the client is notified of the service provider's complaint or grievance procedure</p>	<p>Based on record review, the Agency failed to provide documentation that the complaint procedure had been made available to individuals or their legal guardians for 2 of 8 individuals.</p> <ul style="list-style-type: none"> <li>Grievance/Complaint Procedure (#5 &amp; 8)</li> </ul>		

Tag # 1A31 (CoP) Client Rights	Scope and Severity Rating: D		
<p><b>NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:</b></p> <p>A. A service provider shall not restrict or limit a client's rights except:</p> <p>(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or</p> <p>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or</p> <p>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].</p> <p>B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy.</p> <p>C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights.</p> <p>[09/12/94; 01/15/97; Recompiled 10/31/01]</p>	<p>Based on record review and interview, the Agency failed to ensure the rights of Individuals was not restricted or limited.</p> <p>A review of Agency Individual files found:</p> <ul style="list-style-type: none"> <li>• No documentation of Positive Behavior Plans being reviewed at least quarterly. No reviews found for 11/07 – 11/08. (#2)</li> </ul> <p>A review of Agency Individual files indicated 1 of 8 individuals required Human Rights Approval for the following:</p> <ul style="list-style-type: none"> <li>• MANDT Restraint (#2)</li> </ul>		

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: D		
<p>NMAC 7.26.5.16.C and D  <b>Development of the ISP. Implementation of the ISP.</b> The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities.  [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<p>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 8 individuals.</p> <p>Per Individuals ISP's the following was found with regards to the implementation of ISP Outcomes:</p> <p>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <ul style="list-style-type: none"> <li>• Agency outcomes did not match the ISP outcomes (Individual #3)</li> </ul> <p>Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <ul style="list-style-type: none"> <li>• Agency outcomes did not match the ISP outcomes (Individual #3)</li> </ul>		

Tag # 1A33 Board of Pharmacy - Lic	Scope and Severity Rating: C		
<p><b>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual</b></p> <p><b>6. Display of License and Inspection Reports</b></p> <p>A. The following are required to be publicly displayed:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Current Custodial Drug Permit from the NM Board of Pharmacy</li> <li><input type="checkbox"/> Current registration from the consultant pharmacist</li> <li><input type="checkbox"/> Current NM Board of Pharmacy Inspection Report</li> </ul>	<p>Based on observation the Agency failed to provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, and/or the current New Mexico Board of Pharmacy Inspection Report for 3 of 4 residences.</p> <p>Individual Residence:</p> <ul style="list-style-type: none"> <li>• Current NM Board of Pharmacy Inspection report (#1, 5 &amp; 6)</li> </ul>		

Tag # 1A36 SC Training	Scope and Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p><b>C. Orientation and Training Requirements:</b> Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training <b>Requirements for Direct Support Staff and Internal Service Coordinators</b> Serving Individuals with Developmental Disabilities to include the following:</p> <p>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 5 Service Coordinators.</p> <p>Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:</p> <ul style="list-style-type: none"> <li>• Pre-Service (SC #64)</li> </ul>		

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:</b> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p><b>C.</b> Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(2) <b>Individual-specific training</b> for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</p>	<p>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 5 of 46 Agency Personnel.</p> <ul style="list-style-type: none"> <li>• Individual Specific Training (#59, 60, 61, 64 &amp; 65)</li> </ul>		

Tag # 5I22 SE Agency Case File	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</b></p> <p><b>D. Provider Agency Requirements</b></p> <p>(1) Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDSD. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.</p> <p>(2) The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items:</p> <p>(a) Quarterly progress reports;</p> <p>(b) Vocational assessments (A vocational assessment or profile is an objective analysis of a person's interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDSD;</p> <p>(c) Career development plan as incorporated in the ISP; a career development plan consists of the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks including the individual,</p>	<p>Based on record review, the Agency failed to maintain a confidential case file for 2 of 5 individuals receiving Supported Employment Services.</p> <ul style="list-style-type: none"> <li>• Vocational Assessment (#7 &amp; 8)</li> <li>• Career Development Plan (#8)</li> </ul>		

as well and a review and reporting mechanism for mutual accountability; and  
(d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973.



Tag # 6L14 Residential Case File	Scope and Severity Rating: F		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>A. Residence Case File:</b> For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:</p> <p>(1) Complete and current ISP and all supplemental plans specific to the individual;</p> <p>(2) Complete and current Health Assessment Tool;</p> <p>(3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;</p> <p>(4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);</p> <p>(5) Data collected to document ISP Action Plan implementation</p> <p>(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 4 of 4 Individuals receiving Supported Living Services.</p> <ul style="list-style-type: none"> <li>• Annual ISP (#1, 5 &amp; 6)</li> <li>• ISP Signature Page (#1, 5 &amp; 6)</li> <li>• Addendum A (#1, 5 &amp; 6)</li> <li>• Individual Specific Training (Addendum B) (#1, 5 &amp; 6)</li> <li>• Positive Behavioral Plan (#5)</li> <li>• Speech Therapy Plan (#1 &amp; 6)</li> <li>• Occupational Therapy Plan (#6)</li> <li>• Physical Therapy Plan (#6)</li> <li>• Health Assessment Tool (#5 &amp; 6)</li> <li>• Health Care Plans (#5)</li> <li>• Crisis Plan <ul style="list-style-type: none"> <li>• Diabetes (#5)</li> </ul> </li> <li>• Data Collection/Data Tracking (#5 &amp; 7)</li> <li>• Progress Notes written by DSP and/or Nurses (#1, 5 &amp; 7)</li> <li>• Health Care Providers Written Orders (#1, 5, 6 &amp; 7)</li> <li>• Record of visits of healthcare practitioners (#1, 6 &amp; 7)</li> </ul>		

<p>response to identified changes in condition for at least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> <li>(a) The name of the individual;</li> <li>(b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;</li> <li>(c) Diagnosis for which the medication is prescribed;</li> <li>(d) Dosage, frequency and method/route of delivery;</li> <li>(e) Times and dates of delivery;</li> <li>(f) Initials of person administering or assisting with medication; and</li> <li>(g) An explanation of any medication irregularity, allergic reaction or adverse effect.</li> <li>(h) For PRN medication an explanation for the use of the PRN must include: <ul style="list-style-type: none"> <li>(i) Observable signs/symptoms or circumstances in which the medication is to be used, and</li> <li>(ii) Documentation of the effectiveness/result of the PRN delivered.</li> </ul> </li> <li>(i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis.</li> </ul> <p>(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current</p>			
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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 # 6L25 (CoP) Residential Reqts.	Scope and Severity Rating: F		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>L. Residence Requirements for Family Living Services and Supported Living Services</b></p> <p>(1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has:</p> <ul style="list-style-type: none"> <li>(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;</li> <li>(b) General-purpose first aid kit;</li> <li>(c) When applicable due to an individual's health status, a blood borne pathogens kit;</li> <li>(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;</li> <li>(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;</li> <li>(f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;</li> <li>(g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and</li> <li>(h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.</li> </ul>	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 4 of 4 Supported Living residences.</p> <p>The following items were missing, not functioning or incomplete:</p> <ul style="list-style-type: none"> <li>• Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#1, 5, 6 &amp; 7)</li> <li>• 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 (#7)</li> </ul>		

Tag # 6L26 SL Reimbursement	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES</b></p> <p>A. <b>Reimbursement</b> for Supported Living Services</p> <p>(1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year.</p> <p>(2) <b>Billable Activities</b></p> <p>(a) Direct care provided to an individual in the residence any portion of the day.</p> <p>(b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community.</p> <p>(c) Any activities in which direct support staff provides in accordance with the Scope of Services.</p> <p>(3) Non-Billable Activities</p> <p>(a) The Supported Living Services provider shall not bill DD Waiver for Room and Board.</p> <p>(b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services.</p> <p>(c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 2 of 4 individuals.</p> <p>Individual #1</p> <ul style="list-style-type: none"> <li>• July 1 – 7, 2008 - Agency billed 7 units of Supported Living. Documentation received accounted for 5 units.</li> </ul> <p>Individual #5</p> <ul style="list-style-type: none"> <li>• June 25 – 30, 2008 - Agency billed 6 units of Supported Living. Documentation received accounted for 5 units.</li> <li>• July 1 – 7, 2008 - Agency billed 7 units of Support Living. Documentation received accounted for 3 units.</li> <li>• July 8 – 14, 2008 - Agency billed 7 units of Support Living. Documentation received accounted for 6 units.</li> </ul>		