Date:	June 23, 2009
To:	Bill Myers, Senior Director
Provider:	Dungarvin New Mexico, LLC
Address:	2000 Randolph SE Suite 205
State/Zip:	Albuquerque, NM 87106
CC:	Dave Toeniskoetter, Chief Executive Officer
Address:	Edyth Bush Office 690 S. Cleveland Ave.
State/Zip	St. Paul, MN 55116-1319
E-mail Address:	bmyers@dungarvin.com
Region:	Metro
Survey Date:	April 20 – 23, 2009
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation & Community Access)
Survey Type:	Routine
Team Leader:	Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Cyndie Nielsen, RN, MSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Crystal Lopez-Beck, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Survey #:	Q09.04.D1696.METRO.001.RTN.01

Dear Mr. Myers,

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/Quality Management Bureau is granting your agency a "SUB-STANDARD" certification for significant non-compliance with DDSD Standards and regulations; additionally your agency is being referred to the Internal Review Committee for consideration of remedies and possible sanctions.

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
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	April 20, 2009
Present:	**Dungarvin New Mexico, LLC** Julie Matthews, Director **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor Crystal Lopez-Beck, BA, Healthcare Surveyor Nadine Romero, LBSW, Healthcare Surveyor Cyndie Nielsen, RN, Healthcare Surveyor
Exit Conference Date:	April 23, 2009
Present:	**Dungarvin New Mexico, LLC** Jackie Martinez, Program Director Judy Bencomo, Program Director Cindi Ricker, Program Director Elisa Gallegos, RN Kevin Smith, Employment Coordinator Lisa Littlepage, Program Director Tiffany Baca, Human Resource Specialist BickYee LaMontanaro, Accounting Specialist Julie Matthews, Director Sandy Gallagher, Program Director Christine Sigman, Director Clair HoSang, Human Resource Manager **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor Crystal Lopez-Beck, BA, Healthcare Surveyor Nadine Romero, LBSW, Healthcare Surveyor Cyndie Nielsen, RN, Healthcare Surveyor
Homes Visited	**Number: 11**
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 13 3 - Jackson Class Members 9 - Non-Jackson Class Members 10 - Supported Living 2 - Family Living 7 - Adult Habilitation 1 - Community Access
Persons Served Interviewed	Number: 7
Persons Served Observed	Number: 3 (Two people not available during on site visit and 3 did not respond to Surveyors questions)
Guardians Interviewed	Number: 1
Records Reviewed (Persons Served)	Number: 12
Administrative Files Reviewed	• Billing Records

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

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

Attachment A

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8624.
- 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, hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Attachment B

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

Key to Scope scale:

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

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

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

Key to 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: **Dungarvin New Mexico, LLC – Metro Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation & Community Access)
Monitoring Type: Routine
Date of Survey: **April 20 – 23, 2009**

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A08 Agency Case File - Progress Notes	**Scope & Severity Rating: B**		
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: (3) Progress notes and other service delivery documentation;	Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 1 of 12 Individuals. Current Family Living Progress Notes/Daily Contact Logs • Individual #1 - None found for 5/2008 - 4/2009		

Tag # 1A09 Medication Delivery (MAR)	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include	Medication Administration Records were reviewed for the months of January, February & March 2009. Based on record review, 9 of 12 individuals had Medication Administration Records, which contained missing medications entries and/or other errors. Individual #1 January 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Lamictal (2 times daily) • Tegretol (2 times daily) • Advair (2 times daily) • Calcium (1 time daily) Medication Administration Records did not contain the route of administration for the following medications: • Lamictal (2 times daily) • Tegretol (2 times daily) • Advair (2 times daily) • Calcium (1 times daily) • Fiber Therapy (1 time daily) Medication Administration Records did not contain the dosage of the medication is to be given: • Lamictal (2 times daily) • Tegretol (2 times daily) • Calcium (1 time daily) • Fiber Therapy (1 time daily) Medication Administration Records did not contain the strength of medication is to be given: • Advair (2 times daily)		

observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications.	February 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Lamictal (2 times daily) • Tegretol (2 times daily) • Advair (2 times daily) • Calcium (1 time daily) Medication Administration Records did not contain the route of administration for the following medications: • Lamictal (2 times daily) • Tegretol (2 times daily) • Advair (2 times daily) • Calcium (1 time daily) • Fiber Therapy (1 time daily) Medication Administration Records did not contain the dosage of the medication is to be given: • Lamictal (2 times daily) • Tegretol (2 times daily) • Calcium (1 time daily) • Fiber Therapy (1 time daily) Medication Administration Records did not contain the strength of medication is to be given: • Advair (2 times daily) March 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Lamictal (2 times daily) • Tegretol (2 times daily) • Advair (2 times daily) • Calcium (1 time daily) Medication Administration Records did not contain the route of administration for the		

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.	following medications: • Lamictal (2 times daily) • Tegretol (2 times daily) • Advair (2 times daily) • Calcium (1 time daily) • Fiber Therapy (1 time daily) Medication Administration Records did not contain the dosage of the medication is to be given: • Lamictal (2 times daily) • Tegretol (2 times daily) • Calcium (1 time daily) • Fiber Therapy (1 time daily) Medication Administration Records did not contain the strength of medication is to be given: • Advair (2 times daily) Individual #2 January 2009 Medication Administration Records did not contain the route of administration for the following medications: • Paroxetine HCI 40 mg (1 time daily) • Paroxetine HCL 30 mg (1 time daily) February 2009 Medication Administration Records did not contain the route of administration for the following medications: • Paroxetine HCI 40 mg (1 time daily) • Paroxetine HCL 30 mg (1 time daily) March 2009 Medication Administration Records did not contain the route of administration for the following medications: • Paroxetine HCI 40 mg (1 time daily) • Paroxetine HCL 30 mg (1 time daily)		

	Individual #3 January 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Phenytoin Sodium Ext 100mg (3 times daily) • Aricept 5 mg (1 time daily) • Cephalexin 500 mg (4 times daily) February 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Phenytoin Sodium Ext 100mg (3 times daily) • Aricept 5 mg (1 time daily) March 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Phenytoin Sodium Ext 100mg (3 times daily) • Aricept 5 mg (1 time daily) Individual #4 February 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Depakote 500 mg (1 time daily) March 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Depakote 500 mg (1 time daily) • Sertraline 50 mg (1 time daily) Individual #5 March 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Lisinopril 10 mg (1 time daily)		

	Individual #6 February 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Metoclopramide (4 times daily) Blank – 2/10 (8PM) Individual #7 March 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Abilify 15 mg (1 time daily) • Lexapro 20mg (1 time daily) Individual #10 January 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Patanol 0.1% Eye Drops (2 times daily) February 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Patanol 0.1% Eye Drops (2 times daily) Individual #11 January 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • CBG (Capillary Blood Glucose) Monitoring (4 times daily) Blank – 1/28, 29 & 30 (11:30AM & 2:00PM)		

Tag # 1A09 Medication Delivery - PRN	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include	Based on record review, the Agency failed to maintain PRN Medication Administration Records, which contained all elements required by standard for 6 of 12 individuals. Individual #1 January 2009 Medication Administration Records did not contain the circumstance in which the medication is to be given: • Albuterol Inhaler (PRN) • Advil or Ibuprofen 200 mg (PRN) • Tylenol 500 mg (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Albuterol Inhaler (PRN) • Advil or Ibuprofen 200 mg (PRN) • Tylenol 500 mg (PRN) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Albuterol Inhaler (PRN) • Advil or Ibuprofen 200 mg (PRN) • Tylenol 500 mg (PRN) February 2009 Medication Administration Records did not contain the circumstance in which the medication is to be given: • Albuterol Inhaler (PRN) • Advil or Ibuprofen 200 mg (PRN) • Tylenol 500 mg (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Albuterol Inhaler (PRN) • Advil or Ibuprofen 200 mg (PRN)		

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; **Department of Health** **Developmental Disabilities Supports Division (DDSD)** **Medication Assessment and Delivery Policy - Eff. November 1, 2006** **F. PRN Medication** 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity	• Tylenol 500 mg (PRN) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Albuterol Inhaler (PRN) • Advil or Ibuprofen 200 mg (PRN) • Tylenol 500 mg (PRN) Medication Administration Records did not contain the circumstance in which the medication is to be given: • Albuterol Inhaler (PRN) • Advil or Ibuprofen 200 mg (PRN) • Tylenol 500 mg (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Albuterol Inhaler (PRN) • Advil or Ibuprofen 200 mg (PRN) • Tylenol 500 mg (PRN) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Albuterol Inhaler (PRN) • Advil or Ibuprofen 200 mg (PRN) • Tylenol 500 mg (PRN) Individual #7 March 2009 Medication Administration Records did not contain the circumstance in which the medication is to be given: • Ibuprofen 800 mg (PRN) • Acetaminophen 500 mg (PRN) • Prednisolone 1 % Eye Drops (PRN) Medication Administration Records did not contain the exact amount to be used in a 24 hour period:		

to the individual. **NMAC 16.19.11.8 MINIMUM STANDARDS:** **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff 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.	• Diphenhydramine HCl 25 mg (PRN) No Effectiveness noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 800 mg - PRN - 3/14, 15, 16, 17, 18, 19, 20, 21, 24, 27 & 28 (given 1 time daily) • Diphenhydramine HCl 25 mg - PRN - 3/14 – 3/24 (given 1 time daily) • Acetaminophen 500 mg - PRN - 3/14 – 3/24 (given 1 time daily) Individual #8 February 2009 No Effectiveness noted on the Medication Administration Record for the following PRN medication: • Lorazepam 1 mg - PRN 2/5 (given 1 time) Individual #9 January 2009 Medication Administration Records did not contain the circumstance in which the medication is to be given: • Tylenol 500 mg (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Tylenol 500 mg (PRN) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Tylenol 500 mg (PRN) No Effectiveness noted on the Medication Administration Record for the following PRN medication: • Tylenol 500 mg - PRN 1/25 (2 tablets given 1 time)		

	MAR document does not contain documentation of exact dose medication administered: • Tylenol 500 mg - PRN 1/25 (given 1 time) Individual #10 January 2009 Medication Administration Records did not contain the circumstance in which the medication is to be given: • Atropine 1 % Eye Drops (PRN) • Prednisolone 1 % Eye Drops (PRN) No Effectiveness noted on the Medication Administration Record for the following PRN medication: • Loratadine 10 mg - PRN 1/26 (given 1 time) February 2009 Medication Administration Records did not contain the circumstance in which the medication is to be given: • Atropine 1 % Eye Drops (PRN) • Prednisolone 1 % Eye Drops (PRN) No Effectiveness noted on the Medication Administration Record for the following PRN medication: • Loratadine 10 mg - PRN 2/6, 20, 24, 25, 26, 27 & 28 (given 1 time daily) March 2009 MAR document does not contain the Medication Administration Records did not contain the circumstance in which the medication is to be given: • Atropine 1 % Eye Drops (PRN) • Prednisolone 1 % Eye Drops (PRN) No Effectiveness noted on the Medication Administration Record for the following PRN medication: • Loratadine 10 mg - PRN 3/3, 4, 5, 6, 7, 9, 10 , 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21,		

	22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 1 time daily) Individual #11 January 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 500 mg (PRN) February 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 500 mg (PRN) March 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 500 mg (PRN)		

Tag # 1A12 Reimbursement/Billable Units	Scope and Severity Rating: A		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed, which contained the required information for 1 of 12 individuals. Individual #12 – No daily progress notes were found. The monthly summary provided was not completed by the Family Living Provider. • Agency billed 31 units of Family Living from 1/1/09 through 1/31/2009. Progress notes did not contain a date to justify billing. • Agency billed 31 units of Family Living from 1/1/09 through 1/31/2009. Progress notes did not contain start and end time to justify billing. • Agency billed 31 units of Family Living from 1/1/09 through 1/31/2009. Progress notes did not contain a signature/authenticated name of staff providing the service to justify billing. • Agency billed 31 units of Family Living from 1/1/09 through 1/31/2009. Progress notes did not contain a description of what occurred during the service interval to justify billing. • Agency billed 28 units of Family Living from 2/1/09 through 2/28/2009. Progress notes did not contain a date to justify billing. • Agency billed 28 units of Family Living from 2/1/09 through 2/28/2009. Progress notes did not contain start and end time to justify billing. • Agency billed 28 units of Family Living from 2/1/09 through 2/28/2009. Progress notes did not contain a signature/authenticated name of the staff providing the service to justify billing. • Agency billed 28 units of Family Living from 2/1/09 through 2/28/2009. Progress notes did not contain a description of what occurred		

	during the service interval to justify billing. • Agency billed 31 units of Family Living from 3/1/09 through 3/31/2009. Progress notes did not contain a date to justify billing. • Agency billed 31 units of Family Living from 3/1/09 through 3/31/2009. Progress notes did not contain start and end time to justify billing. • Agency billed 31 units of Family Living from 3/1/09 through 3/31/2009. Progress notes did not contain a signature/authenticated name of staff providing the service to justify billing. • Agency billed 31 units of Family Living from 3/1/09 through 3/31/2009. Progress notes did not contain a description of what occurred during the service interval to justify billing.		

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C**. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 7 of 131 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Basic Health/Orientation (DSP #40) • First Aid (DSP #40) • CPR (DSP #40) • Assisting With Medications (DSP #40 & 98) • Rights & Advocacy (DSP #40 & 98) • Level 1 Health (DSP #40, 49, 90 & 98) • Teaching & Support Strategies (DSP #76) • Positive Behavior Supports Strategies (DSP #40, 98 & 152) • Participatory Communication & Choice Making (DSP #40, 98 & 104)		

Tag # 1A22 Staff Competence	Scope and Severity Rating: E		
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 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	Based on interview, the Agency failed to ensure that training competencies were met for 4 of 13 Direct Service Personnel. When DSP were asked if they received training on the Individuals ISP, the following was reported: • DSP #59 stated, "No." (Individuals #2 & 5) When DSP were asked if they received training on the Individuals Positive Behavioral Supports Plan, the following was reported: • DSP #59 stated, "No." (Individual #2 & 5) When DSP were asked if they received training on the Individuals Physical Therapy Plan, the following was reported: • DSP #59 stated, "No." (Individual #2) • DSP #74 stated, "No." (Individual #6) When DSP were asked if they received training on the Individuals seizure disorder, the following was reported: • DSP #117 stated, "I never received training. The plan is in there but I don't know it." (Per record review Individual #6 requires a Seizure Crisis Plan) When asked what are you supposed to do when there is a medication error the following was reported: • DSP #98 stated, "I flush them down the toilet." Per Agency policy & procedures, "Medications that are dropped, refused, popped out of the bubble pack or not taken for any other reason, will be placed in a designated area awaiting destruction by the pharmacist."		

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.			

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D		
NMAC 7.1.9.9 **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; **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. 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.	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 137 Agency Personnel. • #98 – Date of hire 9/16/2004		

Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: D		
7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: **A. Duty To Report:** **(1)** All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. **(2)** All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property**,** unexpected and natural/expected deaths; and other reportable incidents to include: **(a)** an environmental hazardous condition, which creates an immediate threat to life or health; or **(b)** admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider. **(3)** All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. **B. Notification**: **(1) Incident Reporting:** Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.	Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 13 individuals. Individual #13 • Incident date 9/4/2008 Allegation was neglect. Incident report was received 9/5/2008. Failure to Report. IMB Late & Failure Report indicated incident was "Confirmed."		

Tag # 1A28 (CoP) Incident Mgt. System - Posters	Scope & Severity Rating: D		
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **F. Posting of Incident Management Information Poster:** 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]	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 for 1 of 12 residences: Residence of : • Individual #1		

Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: E		
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 Requirements Eff Date: March 1, 2003** **IV. POLICY STATEMENT** Human Rights Committees are required for	A review of Agency Individual files indicated 4 of 12 individuals required Human Rights Committee Approval for restrictions. No documentation was found regarding Human Rights Approval for the following: • Physical Restraint (MANDT) (Individual #4, 7 & 11) • Cigarette Restriction. No evidence found of Human Rights Committee approval. (Individual #4) • Water turned off at bathroom sink. No evidence found of Human Rights Committee approval. (Individual #11) • Bathroom door left open. No evidence found of Human Rights Committee approval. (Individual #11) • Wheelchair seatbelt used as a restraint. No evidence found of Human Rights Committee approval. (Individual #6)		

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			

Tag # 1A33 Board of Pharmacy - Med Storage	Scope and Severity Rating: A		
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.	Based on interview and observation, the Agency failed to ensure proper storage of medication for 1 of 12 individuals. Observation included: Individual #8 • Suppositories in refrigerator were not in locked compartment.		

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C**. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (2) **Individual-specific training** for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.	Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 2 of 132 Agency Personnel. • Individual Specific Training (#40 & 60)		

Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: F		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES** **B. Home Studies**. The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS** **D. Scope of DDSD Agreement** (4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite; **NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER** **ELIGIBLE PROVIDERS:** I. **Qualifications for community living service providers:** There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards.	Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 2 of 2 individuals. • DDSD Approval for Subcontractor (#1 & 12)		

(1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.			

Tag # 6L14 Residential Case File	Scope and Severity Rating: E		

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007
CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS
A. Residence Case File: For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:
(1) Complete and current ISP and all supplemental plans specific to the individual;
(2) Complete and current Health Assessment Tool;
(3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;
(4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);
(5) Data collected to document ISP Action Plan implementation
(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;
	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 4 of 12 Individuals receiving Family Living Services and Supported Living Services.
	• Addendum A (#7)
	• Positive Behavioral Plan (#2)
	• Health Assessment Tool (#2)
	• Crisis Plan
	  • Asthma (Per record review the individual is required to have a plan). (#1)
	• Progress Notes written by DSP and/or Nurses
	  ° Individual #12 - None found for February 2009 – April 2009
	• Health Care Providers Written Orders (#1)		

(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 # 6L25 (CoP) Residential Reqts.	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services** (1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has: (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence; (b) General-purpose first aid kit; (c) When applicable due to an individual's health status, a blood borne pathogens kit; (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats; (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone; (f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift; (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.	Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 1 of 12 Supported Living and Family Living residences. The following items were missing, not functioning or incomplete: • 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 (#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 (#12)		

Tag # 6L27 FL Reimbursement	Scope and Severity Rating: A		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES** B. Reimbursement for Family Living Services (1) Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year. (2) Billable Activities shall include: (a) Direct support provided to an individual in the residence any portion of the day; (b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and (c) Any other activities provided in accordance with the Scope of Services. (3) Non-Billable Activities shall include: (a) The Family Living Services Provider Agency may not bill the for room and board; (b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and (c) Family Living services may not be billed for the same time period as Respite. (d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one midnight to the following midnight.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 1 of 2 individuals. Individual #12 • January 2009 - Agency billed 31 units of Family Living. Documentation received accounted for 1 unit. • February 2009 - Agency billed 28 units of Family Living. No documentation found to justify billing. • March 2009 - Agency billed 31 units of Family Living. No documentation found to justify billing.		