Date: April 22, 2009

To: Kathy Kautz, Executive Director
Provider: EsperanZa Developmental Services
Address: 72 West Earl Cummings Loop
State/Zip: Roswell, NM 88203

CC: David Rodriguez, Director of Administrative Services
Address: 72 West Earl Cummings Loop
State/Zip Roswell, NM 88203

E-mail Address: katscan61@yahoo.com

Region: Southeast
Survey Date: March 2 – 19, 2009
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living, Independent Living & Family 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: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Cynthia Nielsen, MSN, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Survey #: Q09.03.28173309.SE.001.RTN.01

Dear Ms. Kautz,

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

Survey Process Employed:

Entrance Conference Date:	March 2, 2008	
Present:	**EsperanZa Developmental Services** Sarah Sanchez, Human Resources Director **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor Cynthia Nielsen, MSN, RN, Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor	
Exit Conference Date:	March 13, 2009	
Present:	**EsperanZa Developmental Services** Kathy Kautz, Executive Director Claudia Olivarria, Family Living Coordinator Christina Matta, RN Eugene Vigil, Supported Employment Program Coordinator Dolores Salazar, Family Living Director John Pleasant, Risk Manager Nancy Carrasco, Senior Team Lead **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor Cynthia Nielsen, MSN, RN, Healthcare Surveyor (via teleconference) **DDSD - Southeast Regional Office** Jon Hellebust, Regional Director	
Homes Visited	**Number:**	**14**
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	16 13 - Non Jackson 3 - Jackson Class Members 8 - Supported Living 7 - Family Living 1 - Independent Living 15 - Adult Habilitation 6 - Community Access 10 - Supported Employment
Persons Served Interviewed	Number:	13
Persons Served Observed	Number:	3 (One individual was not available during on site -visit and two individual did not respond to the surveyors questions)
Records Reviewed (Persons Served)	Number:	16
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, 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.

<table>
<tr><td colspan="3"></td><td colspan="3">SCOPE</td></tr>
<tr><td rowspan="6">SEVERITY</td><td></td><td></td><td>Isolated
01% - 15%</td><td>Pattern
16% - 79%</td><td>Widespread
80% - 100%</td></tr>
<tr><td rowspan="2">High Impact</td><td>Immediate Jeopardy to individual health and or safety</td><td>J.</td><td>K.</td><td>L.</td></tr>
<tr><td>Actual harm</td><td>G.</td><td>H.</td><td>I.</td></tr>
<tr><td rowspan="2">Medium Impact</td><td rowspan="2">No Actual Harm Potential for more than minimal harm</td><td>D.</td><td rowspan="2">E.</td><td>F. (3 or more)</td></tr>
<tr><td>D. (2 or less)</td><td>F. (no conditions of participation)</td></tr>
<tr><td>Low Impact</td><td>No Actual Harm Minimal potential for harm.</td><td>A.</td><td>B.</td><td>C.</td></tr>
</table>

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: **EsperanZa Developmental Services - Southeast Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living, Family Living & Independent Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Routine
Date of Survey: **March 2 - 19, 2009**

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A08 Agency Case File	**Scope and 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: (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;	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 6 of 16 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • ISP Signature Page (#11) • Addendum A (#1) • Speech Therapy Plan (#13 & 16) • Occupational Therapy Plan (#3, 15 & 16) • Physical Therapy Plan (#11)		

(2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.			

Tag # 1A09 Medication Delivery (MAR)	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall	Medication Administration Records were reviewed for the months of October, November & December 2008. Based on record review, 1 of 16 individuals had Medication Administration Records, which contained missing medications entries and/or other errors. Individual #15 November 2008 Medication Administration Records for the following medications did not contain the diagnosis for which the medication is prescribed: • Depakote 500 mg • Resperidal 1 mg • Lorazapam 1 mg • Depakote ER 250 mg • Risperidone 2 mg • Amox-Clov 875 mg • Azithromycen 250 mg December 2008 Medication Administration Records for the following medications did not contain the diagnosis for which the medication is prescribed: • Depakote 500 mg • Depakote ER 250 mg • Risperidone 2 mg • Amox-Clov 875 mg • Azithromycen 250 mg		

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

(x) The name and initials of all staff 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.			

Tag # 1A09 Medication Delivery - PRN	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall	Based on record review, the Agency failed to maintain PRN Medication Administration Records, which contained all elements required by standard for 1 of 16 individuals. Individual #15 November 2008 MAR document does not contain the circumstances in which the medication is to be used: • Lorazapam 1 mg • Clonidine 0.2 mg December 2008 MAR document does not contain the circumstances in which the medication is to be used: • Lorazapam 1 mg • Clonidine 0.2 mg MAR document does not contain the exact amount to be used in a 24 hour period. • Clonidine 0.2 mg		

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

(x) The name and initials of all staff 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.			

Tag # 1A12 Reimbursement/Billable Units	Scope and Severity Rating: B		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service.	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 11 of 16 individuals. Individual #1 • Agency billed 72 units of Adult Habilitation from 11/24/2008 through 11/30/2008. Progress notes did not contain start and end time of service encounters to justify billing. • Agency billed 432 units of Adult Habilitation from 12/1/2008 through 12/31/2008. Progress notes did not contain start and end time of service encounters to justify billing. Individual #2 • Agency billed 299 units of Adult Habilitation from 12/1/2008 through 12/31/2008. Progress notes did not contain start and end time of service encounters to justify billing. Individual #3 • Agency billed 378 units of Adult Habilitation from 10/1/2008 through 10/31/2008. Progress notes did not contain start and end time of service encounters to justify billing. • Agency billed 28 units of Family Living from 10/1/2008 through 10/31/2008. Progress notes did not contain signature/authenticated name of staff providing the service to justify billing. • Agency billed 274 units of Adult Habilitation from 11/1/2008 through 11/30/2008. Progress notes did not contain start and end time of service encounters to justify billing. • Agency billed 24 units of Family Living from 11/1/2008 through 11/30/2008. Progress notes did not contain		

	signature/authenticated name of staff providing the service to justify billing. • Agency billed 192 units of Adult Habilitation from 12/1/2008 through 12/31/2008. Progress notes did not contain start and end time of service encounters to justify billing. • Agency billed 29 units of Family Living from 12/1/2008 through 12/31/2008. Progress notes did not contain signature/authenticated name of staff providing the service to justify billing. Individual #4 • Agency billed 10 units of Supported Employment from 12/9/2008 through 12/30/2008. Progress notes did not contain end time of service encounters for to justify billing. Individual #5 • Agency billed 160 units of Adult Habilitation from 10/1/2008 through 10/31/2008. Progress notes did not contain start and end time of service encounters to justify billing. • Agency billed 440 units of Adult Habilitation from 11/1/2008 through 11/30/2008. Progress notes did not contain start and end time of service encounters to justify billing. • Agency billed 448 units of Adult Habilitation from 12/1/2008 through 12/31/2008. Progress notes did not contain start and end time of service encounters to justify billing. Individual #6 • Agency billed 444 units of Adult Habilitation from 10/1/2008 through 10/31/2008. Progress notes did not contain start and end time of service encounters to justify billing.		

	• Agency billed 252 units of Adult Habilitation from 11/1/2008 through 11/30/2008. Progress notes did not contain start and end time of service encounters to justify billing. • Agency billed 288 units of Adult Habilitation from 12/1/2008 through 12/31/2008. Progress notes did not contain start and end time of service encounters to justify billing. Individual #8 • Agency billed 4 units of Community Access on 12/21 & 22/2008. Progress notes did not contain start and end time of service encounters to justify billing. • Agency billed 32 units of Community Access from 12/15 through 12/18 & 12/23 through 25/2008. Progress notes did not contain signature/authenticated name of staff providing the service to justify billing Individual #9 • Agency billed 552 units of Adult Habilitation from 10/1/2008 through 10/31/2008. Progress notes did not contain start and end time of service encounters to justify billing. • Agency billed 456 units of Adult Habilitation from 11/1/2008 through 11/30/2008. Progress notes did not contain start and end time of service encounters to justify billing. • Agency billed 360 units of Adult Habilitation from 12/1/2008 through 12/31/2008. Progress notes did not contain start and end time of service encounters to justify billing. Individual #10 • Agency billed 428 units of Adult Habilitation from 10/1/2008 through 10/31/2008. Progress notes did not contain start and end time of service encounters to justify billing.		

	• Agency billed 432 units of Adult Habilitation from 11/1/2008 through 11/30/2008. Progress notes did not contain start and end time of service encounters to justify billing. • Agency billed 432 units of Adult Habilitation from 12/1/2008 through 12/31/2008. Progress notes did not contain start and end time of service encounters to justify billing. • Agency billed 9 units of Supported Employment from 10/1/2008 through 10/31/2008. Progress notes did not contain end time of service encounters for to justify billing. • Agency billed 2 units of Supported Employment from 11/1/2008 through 11/30/2008. Progress notes did not contain end time of service encounters for to justify billing. • Agency billed 10 units of Supported Employment from 12/1/2008 through 12/31/2008. Progress notes did not contain end time of service encounters for to justify billing. Individual #13 • Agency billed 528 units of Adult Habilitation from 10/1/2008 through 10/31/2008. Progress notes did not contain start and end time of service encounters to justify billing. • Agency billed 432 units of Adult Habilitation from 11/1/2008 through 11/30/2008. Progress notes did not contain start and end time of service encounters to justify billing. • Agency billed 360 units of Adult Habilitation from 12/1/2008 through 12/31/2008. Progress notes did not contain start and end		

	time of service encounters to justify billing. Individual #15 • Agency billed 28 units of Family Living from 10/1/2008 through 10/31/2008. Progress notes did not contain signature/authenticated name of staff providing the service to justify billing. • Agency billed 552 units of Adult Habilitation from 10/1/2008 through 10/31/2008. Progress notes did not contain signature/authenticated name of staff providing the service to justify billing. • Agency billed 22 units of Family Living from 11/1/2008 through 11/30/2008. Progress notes did not contain signature/authenticated name of staff providing the service to justify billing. • Agency billed 336 units of Adult Habilitation from 11/1/2008 through 11/30/2008. Progress notes did not contain signature/authenticated name of staff providing the service to justify billing. • Agency billed 13 units of Family Living from 12/1/2008 through 12/31/2008. Progress notes did not contain signature/authenticated name of staff providing the service to justify billing. • Agency billed 336 units of Adult Habilitation from 12/1/2008 through 12/31/2008. Progress notes did not contain signature/authenticated name of staff providing the service to justify billing.		

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: F		
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 138 of 158 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #40, 42, 49, 51, 55, 56, 61, 64, 65, 72, 73, 74, 83, 87, 88, 89, 93, 95, 96, 97, 98, 103, 104, 105, 107, 111, 112, 113, 115, 124, 130, 134, 136, 137, 147, 148, 153, 154, 160, 162, 163, 172 & 193) • Basic Health/Orientation (DSP #40, 42, 49, 51, 53, 56, 61, 64, 65, 66, 72, 73, 77, 83, 87, 88, 89, 90, 91, 92, 93, 95, 96, 97, 98, 103, 104, 105, 107, 111, 112, 113, 115, 119, 123, 124, 130, 134, 136, 137, 147, 148, 153, 154, 163, 172, 176 & 193) • Person-Centered Planning (1-Day) (DSP #48, 51, 61, 63, 64, 66, 72, 73, 82, 83, 90, 91, 92, 95, 96, 98, 100, 104, 105, 111, 112, 116, 118, 122, 124, 125, 130, 133, 134, 136, 137, 147, 150, 152, 153, 154, 160, 163, 166, 182, 187, 190, 192 & 193) • First Aid (DSP #43, 48, 51, 52, 57, 58, 59, 60, 61, 64, 67, 68, 70, 73, 75, 80, 81, 82, 83, 91, 92, 94, 95, 99, 101, 102, 104, 108, 109, 110, 112, 113, 118, 128, 129, 132, 134, 145, 146, 147, 149, 154, 157, 158, 159, 160, 163, 165, 166, 168, 172, 173, 174, 179, 180, 181, 184, 186, 187, 188, 190, 191, 193 & 197) • CPR (DSP #43, 48, 51, 52, 57, 58, 59, 60, 61, 64, 67, 68, 70, 73, 75, 80, 81, 82, 83, 91, 92, 94, 95, 99, 101, 102, 104, 108, 109, 110, 112, 113, 118, 128, 129, 132, 134, 145, 146, 147,		

	149, 154, 157, 158, 159, 160, 163, 165, 166, 168, 172, 173, 174, 179, 180, 181, 184, 186, 187, 188, 190, 191, 192, 193 & 197) • Assisting With Medications (DSP #43, 45, 47, 50, 57, 58, 64, 66, 67, 68, 73, 81, 83, 95, 96, 99, 101, 102, 104, 111, 112, 120, 131, 133, 134, 135, 141, 142, 143, 145, 146, 149, 151, 153, 154, 155, 156, 157, 158, 159, 161, 164, 168, 170, 171, 174, 177, 180, 187, 189, 190, 191, 193, 195 & 196) • Rights & Advocacy (DSP #46, 63, 73, 133, 135, 145, 155, 164, 169, 170, 171, 172, 174, 178, 182, 183, 184, 187, 188, 191, 192, 193, 195 & 197) • Level 1 Health (DSP #46, 73, 78, 85, 116, 151, 164, 169, 170, 171, 173, 174, 178, 182, 183, 184, 192, 193 & 197) • Teaching & Support Strategies (DSP #73, 135, 145, 151, 172, 174, 178, 182, 187, 188, 190 & 193) • Positive Behavior Supports Strategies (DSP #63, 69, 73, 78, 85, 94, 133, 135, 149, 157, 159, 169, 170, 171, 172, 173, 174, 178, 181, 182, 183, 184, 190, 191, 192, 193, 195 & 197) • Participatory Communication & Choice Making (DSP #46, 54, 63, 69, 73, 75, 78, 79, 85, 116, 133, 135, 151, 164, 165, 167, 169, 170, 171, 172, 173, 174, 178, 182, 183, 184, 187, 188, 190, 191, 192 & 193)		

Tag # 1A22 Staff Competence	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. **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	Based on interview, the Agency failed to ensure that training competencies were met for 3 of 26 Direct Service Personnel. When DSP were asked if they received training on the Individual's ISP, the following was reported: • DSP #152 stated, "No. I read it." When DSP were asked if they received training on Diabetes and what would they do if there is high blood sugar , the following was reported: • DSP #125 stated, "I don't know. "I was not trained." (Per record review the Individual requires a crisis plan for risk for hypoglycemia/hyperglycemia). • DSP#146 stated, "Take a reading from his blood meter and if it's high, give him something to eat." (Per record review the Individual has a diagnosis of diabetes)		

Individuals with Developmental Disabilities; and (5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support. (6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows: (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.			

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 9 of 162 Agency Personnel. • #40 – Date of Hire 1/20/2009 • #59 – Date of Hire 7/23/2007 • #89 – Date of Hire 2/3/2009 • #97 – Date of Hire 1/20/2009 • #103 – Date of Hire 1/5/2009 • #110 – Date of Hire 10/8/2007 • #140 – Date of Hire 4/30/2007 • #148 – Date of Hire 1/20/2009 • #149 – Date of Hire 7/9/2007		

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: D		
NMAC 7.1.12.8 **REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED**: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-	Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 4 of 162 Agency Personnel. • #69 – Date of Hire 2/25/2008 • #89 – Date of Hire 2/3/2009 • #97 – Date of Hire 1/20/2009 • #197 – Date of Hire 9/28/2006		

referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. **Chapter 1.IV.** General Provider Requirements. D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.			

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: E		
NMAC 7.1.13.10 **INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.	Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 96 of 162 Agency Personnel. • Abuse, Neglect & Exploitation Incident Management Training (#43, 44, 45, 46, 50, 51, 52, 54, 55, 57, 58, 60, 61, 63, 64, 68, 69, 70, 72, 73, 75, 76, 79, 81, 83, 84, 85, 86, 89, 91, 92, 94, 95, 99, 101, 104, 108, 109, 110, 112, 113, 116, 120, 124, 128, 129, 131, 133, 135, 139, 140, 141, 143, 145, 146, 149, 150, 151, 154, 155, 157, 158, 159, 160, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 174, 175, 177, 179, 180, 181, 183, 184, 185, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196 & 197) When DSP were asked what two State Agencies is suspected Abuse, Neglect and Exploitation reported; the following was reported: • DSP #146 stated, “I don’t know.” • DSP #144 stated, “My supervisor and police.”		

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: D		
NMAC 7.1.13.10 **INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. E. **Consumer and Guardian Orientation Packet:** Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of abuse, neglect or exploitation for 1 of 16 Individuals. • Parent/Guardian Incident Management (Abuse, Neglect & Exploitation) Training (#9)		

Tag # 1A31 (CoP) Client Rights	Scope and Severity Rating: E		
NMAC 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]	Based on record review, the Agency failed to follow DDSD Policy regarding Human Rights Committee Requirements for. A review of Agency Individual files indicated 3 of 16 Individuals required Human Rights Committee Approval for restrictions. (Individual #2, 4 & 14) No documentation was found regarding Human Rights Approval for the following: • Physical Restraint (Mandt) - (#2, 4 & 14)		

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℉ - 46℉ 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℉) 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 record review and observation, the Agency failed to ensure proper storage of medication for 2 of 16 individuals. Observation included: Individual #5 • Tussin expired 8/2008 stored with current medication. Individual #14 • Milk of Magnesia did not have bottle cap and was covered with a piece of foil.		

Tag # 1A33 Board of Pharmacy - Lic	Scope and Severity Rating: B		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **6. Display of License and Inspection Reports** A. The following are required to be publicly displayed: □ Current Custodial Drug Permit from the NM Board of Pharmacy □ Current registration from the consultant pharmacist □ Current NM Board of Pharmacy Inspection Report	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, or the current New Mexico Board of Pharmacy Inspection Report for 5 of 15 residences: Individual Residence: The following were not found or not current: • Current Registration of Consulting Pharmacist (#4, 5, 8, 11 & 14) • Current NM Board of Pharmacy Inspection report (#8 & 11)		

Tag # 1A36 SC Training	Scope and Severity Rating: B		
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	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 3 of 4 Service Coordinators. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed: • Pre-Service Manual (SC #203) • Level 1 Health (SC #200 & 201)		

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 4 of 162 Agency Personnel. • Individual Specific Training (#152, 168, 178 & 196)		

Tag # 5I22 SE Agency Case File	Scope and Severity Rating: B		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS** **D. Provider Agency Requirements** (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. (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: (a) Quarterly progress reports; (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; (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,	Based on record review, the Agency failed to maintain a confidential case file for each individual for 3 of 10 individuals receiving Supported Employment Services. The following were not found, incomplete and/or not current: • Vocational Assessment (#7 & 9) • Career Development Plan (#5, 7 & 9)		

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 # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.	Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 4 of 16 individuals. • Auditory Evaluation ○ Per ISP, auditory evaluation to be scheduled. No evidence of exam being completed found. (#2, 6 & 13) • Dental Examination ○ Per ISP, dental examination to be scheduled. No evidence of exam being completed found. (#13 & 16) • Vision Examination ○ Per ISP, vision examination to be scheduled. No evidence of exam being completed found. (#13)		

b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse. (c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition. (4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT. (5) That the physical property and grounds are free of hazards to the individual's health and safety. (6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following: (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).			

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

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
	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 13 of 15 Individuals receiving Family Living Services or Supported Living Services.
	• Current Emergency & Personal Identification
	  ◦ Not Current (3, 4, 10, 11, 12 & 14)
	• Annual ISP (#11 & 15)
	• ISP Signature Page (#1, 2, 3, 5, 12, 13, 14 & 15)
	• Addendum A (#1, 2, 5, 8, 11, 12 & 15)
	• Individual Specific Training (Addendum B) (#11 & 15)
	• Positive Behavioral Plan (#2, 3, 4, 5, 8 & 15)
	• Positive Behavior Support Crisis Plan (#8 & 11)
	• Speech Therapy Plan (#2, 3, 7 & 15)
	• Occupational Therapy Plan (#3 & 15)
	• Special Health Care Needs
	  ◦ Meal Time Plan (#14)
	  ◦ Nutritional Plan (#3)
	• Health Assessment Tool (#5, 8, 12, 13 & 14)
	• Crisis Plan:
	  ◦ Seizures (#7 & 14)
	  ◦ Choking Risk (#15)
	  ◦ Asthma (#3)
	  ◦ Cardiac Condition (#3)
	  ◦ Allergies (#3)		

least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and	• Progress Notes/Daily Contacts Logs for the past month (#1, 2, 3, 4, 5, 8, 11, 12, 14 & 15) • Data Collection/Data Tracking (#1, 2, 3, 4, 5, 8, 11, 12, 14 & 15) • Progress Notes written by DSP and/or Nurses (#1, 3, 5, 7, 10, 12 & 14) • Health Care Providers Written Orders (#3, 7, 12 & 13) • Record of visits of healthcare practitioners (#12 & 13) • Medication Administration Record (MAR) for the past three months (#12)		

(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.			

Tag # 6L17 Reporting Requirements	Scope and Severity Rating: A		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **D. Community Living Service Provider Agency Reporting Requirements:** All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation: (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members.	Based on record review, the Agency failed to complete written quarterly status reports for 1 of 16 individuals receiving Community Living Services. Supported Living Quarterly Reports • Individual 13 - None found from 10/2008 - 12/2008		

Tag # 6L25 (CoP) Residential Reqts.	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services** (1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has: (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence; (b) General-purpose first aid kit; (c) When applicable due to an individual's health status, a blood borne pathogens kit; (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats; (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone; (f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift; (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.	Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 8 of 14 Supported Living and Family Living residences. The following items were not found, not functioning or incomplete: • General-purpose first aid kit (#3 & 12) • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#3, 12, 13 & 15) • Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#1, 12 & 15) • 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 (#8, 10, 11, 12 & 15) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 10, 12, 13 & 15)		

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 7 individuals. Individual #3 • October 2008 - Agency billed 28 units of Family Living. Documentation received accounted for 8 units. • November 2008 - Agency billed 24 units of Family Living. Documentation received accounted for 11 units. • December 2008 - Agency billed 29 units of Family Living. Documentation received accounted for 5 units.		