Date: July 9, 2009

To: Linda Schroeder, Quality Assurance Director
Provider: Families Plus, Inc.
Address: 1698 Rio Bravo Blvd. SW Suite L
State/Zip: Albuquerque, New Mexico 87105

CC: Carol Matthews, Board President
Address: 4601 Sunlight Lane SW
State/Zip Albuquerque, New Mexico 87105

Region: Northwest, Southeast & Southwest
Survey Date: June 8 - 18, 2009
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Family Living)
Survey Type: Routine
Team Leader: Crystal Lopez-Beck, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Barbara Czinger, MSW, LISW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Cynthia Nielsen, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Schroeder,

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 505-222-6625, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Crystal Lopez-Beck

Crystal Lopez-Beck, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	June 8, 2009
Present:	**Families Plus, Inc** Vernita Bullhorse, Billing Manager Brenda Webb, Assistant to the Administrator **DOH/DHI/QMB** Crystal Lopez-Beck, BA, NW, SE & SW Regions Team Lead, Healthcare Surveyor Stephanie Martinez de Berenger, MPA, GCDF, Metro Region Survey Team Lead, Healthcare Surveyor Nadine Romero, LBSW, Healthcare Surveyor Barbara Czinger, MSW, LISW, Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor Florie Alire, RN, Healthcare Surveyor
Exit Conference Date:	June 18, 2009
Present:	**Families Plus, Inc.** Linda Schroeder, Quality Assurance Manager Vernita Bullhorse, Billing Manager Perry Pierce, Human Resources Brenda Webb, Administrative Assistant Marie Bates, Training Department Kay Welsh, NW Service Coordinator (via phone) Rowan Rayne, SW Service Coordinator (via phone) **DOH/DHI/QMB** Crystal Lopez-Beck, BA, NW, SE & SW Regions Team Lead, Healthcare Surveyor Nadine Romero, LBSW, Healthcare Surveyor
Homes Visited	Number: 12
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 12 0 - Jackson Class Members 12 - Non-Jackson Class Members 12 - Family Living
Persons Served Interviewed	Number: 6
Persons Served Observed	Number: 6 (one individual did not want to participate in the interview, three individuals were unable to answer interview questions and two were unavailable during the on-site week of June 15, 2009.)
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		
SEVERITY			**Isolated 01% - 15%**	**Pattern 16% - 79%**	**Widespread 80% - 100%**
	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.

Attachment C

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

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

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

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

The following limitations apply to the IRF process:

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

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

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

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

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

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

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

Agency: **Families Plus, Inc. - Northwest, Southeast & Southwest Regions**
Program: Developmental Disabilities Waiver
Service: Community Living (Family Living)
Monitoring Type: Routine Survey
Date of Survey: **June 8 - 18, 2009**

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A07 SSI Payments	**Scope and Severity Rating: C**		
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. C. Provider Agency Financial Records and Accounting: Each individual served will be presumed able to manage his or her own funds unless the ISP documents justified limitations or supports for self-management, and where appropriate, reflects a plan to increase this skill. All Provider Agencies shall maintain and enforce written policies and procedures regarding the use of the individual's SSI payments or other personal funds, including accounting for all spending by the Provider Agency, and outlining protocols for fulfilling the responsibilities as representative payee if the agency is so designated for an individual. **Code of Federal Regulations:** **§416.635 What are the responsibilities of your representative payee…**	Based on interview, the Agency failed to maintain and enforce written policies and procedures regarding the use of individuals' SSI payments or other personal funds. When #65 was asked if the Agency had policies and procedures regarding the use of individuals' SSI payments or other personal funds, the following was reported: #65 stated, "We haven't had a person receiving rep payee services in a long time so I'm not sure how it goes. I'm sure we would set up an account and monitor."		

A representative payee has a responsibility to: (a) Use the benefits received on your behalf only for your use and benefit in a manner and for the purposes he or she determines under the guidelines in this subpart, to be in your best interests; (b) Keep any benefits received on your behalf separate from his or her own funds and show your ownership of these benefits unless he or she is your spouse or natural or adoptive parent or stepparent and lives in the same household with you or is a State or local government agency for whom we have granted an exception to this requirement; (c) Treat any interest earned on the benefits as your property; (d) Notify us of any event or change in your circumstances that will affect the amount of benefits you receive, your right to receive benefits, or how you receive them; (e) Submit to us, upon our request, a written report accounting for the benefits received on your behalf, and make all supporting records available for review if requested by us; (f) Notify us of any change in his or her circumstances that would affect performance of his/her payee responsibilities; and §416.640 Use of benefit payments. ***Current maintenance***. We will consider that payments we certify to a representative payee have been used for the use and benefit of the beneficiary if they are used for the beneficiary's current maintenance. Current maintenance includes costs incurred in obtaining food, shelter, clothing, medical care and personal comfort items. **§416.665 How does your representative payee account for the use of benefits…** Your representative payee must account for the use of your benefits. We require written reports from your representative payee at least once a year (except for certain State institutions that participate in a separate onsite review program). We may verify			

how your representative payee used your benefits. Your representative payee should keep records of how benefits were used in order to make accounting reports and must make those records available upon our request.			

Tag # 1A08 Agency Case File	Scope and Severity Rating: C		
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; (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	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 10 of 12 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • Current Emergency & Personal Identification Information ° Not Found (#11 & 12) • Annual ISP (#3 & 11) • ISP Signature Page (#3 & 10) • Addendum A (#3 & 10) • Individual Specific Training Section (ISP) (#3) • ISP Teaching & Support Strategies (#3, 4, 6, 9, 10 & 12) • Positive Behavioral Plan (#1, 3 & 6) • Positive Behavioral Crisis Plan (#3, 6 & 8) • Speech Therapy Plan (#5, 8, 9 & 12) • Occupational Therapy Plan (#1 & 8)		

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 # 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 4 of 12 Individuals. Family Living Progress Notes/Daily Contact Logs • Individual #3 - None found for 1/2009. • Individual #10 - None found for 9/2008 & 1/2009. • Individual #11 - None found for 5/2008 & 1/2009. • Individual #12 - None found for 1/2009.		

Tag # 1A09 Medication Delivery (MAR)	Scope and Severity Rating: F		
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	Medication Administration Records (MAR) were reviewed for the months of February, March & April 2009. Based on record review, 10 of 12 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #1 During on-site survey (June 8 - 18, 2009) Physician orders were requested. As of June 18, 2009 Physician orders had not been provided. March 2009 During on-site survey (June 8 - 18, 2009) Medication Administration Records were requested for the month of March 2009. As of June 18, 2009, Medication Administration Records had not been provided. Individual #2 During on-site survey (June 8 - 18, 2009) Physician orders were requested. As of June 18, 2009 Physician orders had not been provided. Individual #3 February 2009 During on-site survey (June 8 - 18, 2009) Medication Administration Records were requested for the month of February 2009. As of June 18, 2009, Medication Administration Records had not been provided. March 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Clonidine 0.2mg/4ml (2 times daily) – Blank 3/19 (PM).		

use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications.	Medication Administration Records contain the following medications. No Physician's orders were found for the following: • Clonidine 0.2mg/4ml (2 times daily) • Fluniosolide 0.025% (2 sprays) (2 times daily) April 2009 Medication Administration Records contain the following medications. No Physician's orders were found for the following: • Clonidine 0.2mg/4ml (2 times daily) • Fluniosolide 0.025% (2 sprays) (2 times daily) Individual #5 February 2009 Medication Administration Records contain the following medications. No Physician's orders were found for the following: • Toprol XL 25mg (1 time daily) • Multi-Vitamin (1 time daily) March 2009 Medication Administration Records contain the following medications. No Physician's orders were found for the following: • Toprol XL 25mg (1 time daily) • Multi-Vitamin (1 time daily) April 2009 Medication Administration Records contain the following medications. No Physician's orders were found for the following: • Toprol XL 25mg (1 time daily) • Multi-Vitamin (1 time daily) Individual #6 February 2009		

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.	Physician's orders indicated the following medication were to be given. Medications were not documented on the Medication Administration Records for the following medication: • Clonazepam 0.5mg (2 times daily) • Lorazepam 1 mg (2 times daily & PRN) Review of the records found no MAR, but a "Controlled Substance Log." The document did not distinguish between routine & PRN for the following medications: • Lorazepam 1 mg (2 times daily & PRN) Medication Administration Records contain the following medications. No Physician's orders were found for the following medications: • Invega 6mg (1 time daily) • Zyprexa 10mg (2 times daily) March 2009 Physician's orders indicated the following medication were to be given. Medications were not documented on the Medication Administration Records for the following medication: • Clonazepam 0.5mg (2 times daily) • Lorazepam 1 mg (2 times daily & PRN) Review of the records found no MAR, but a "Controlled Substance Log." The documentation did not distinguish between routine & PRN for the following medications: • Lorazepam 1 mg (2 times daily & PRN) As indicated by Physician's orders Lorazepam (Ativan) 1mg is to be given as follows: 2 pills 2 times daily & PRN. Review of the records found no MAR, but a "Controlled Substance Log", which indicated during March 1 - 31, 2009 Lorazepam was given as follows: 2 pills in the		

	AM , 1 pill in the PM and PRN. Medication Administration Records contain the following medications. No Physician's orders were found for the following medications: • Invega 6mg (1 time daily) • Zyprexa 10mg (2 times daily) April 2009 Physician's orders indicated the following medication were to be given. Medications were not documented on the Medication Administration Records for the following medication: • Clonazepam 0.5mg (2 times daily) • Lorazepam 1mg (2 times daily) Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard: • Lorazepam 1mg or 2mg As indicated by Physician's orders Lorazepam (Ativan) 1mg is to be given as follows: 2 pills 2 times daily & PRN. Review of the records found no MAR, but a "Controlled Substance Log", which indicated during April 1 - 30, 2009 Lorazepam was given as follows: 2 pills in the AM , 1 pill in the PM and PRN. Medication Administration Records contain the following medications. No Physician's orders were found for the following medications: • Invega 6mg (1 time daily) • Zyprexa 10mg (2 times daily) Individual #7 During on-site survey (June 8 - 18, 2009) Physician orders were requested. As of June 18,		

	2009 Physician Orders had not been provided. February 2009 Medication Administration Records did not contain the strength/dosage of the medication which is to be given: • Glycopyrrolate 10cc (3 times daily) • Metoclopramide 10cc (3 times daily) • Carafate 10cc (2 times daily) • Baclofen 2cc (3 times daily) March 2009 Medication Administration Records did not contain the strength/dosage of the medication which is to be given: • Glycopyrrolate 10cc (3 times daily) • Metoclopramide 10cc (3 times daily) • Carafate 10cc (2 times daily) • Baclofen 2cc (3 times daily) April 2009 Medication Administration Records did not contain the strength/dosage of the medication which is to be given: • Glycopyrrolate 10cc (3 times daily) • Metoclopramide 10cc (3 times daily) • Carafate 10cc (2 times daily) • Baclofen 2cc (3 times daily) Individual #8 During on-site survey (June 8 - 18, 2009) Physician orders were requested. As of June 18, 2009 Physician orders had not been provided.		

	February 2009 As indicated by the Medication Administration Records the individual is to take Fluvoxamine 100mg (2 times daily). According to the Record of Prescriptions, Fluvoxamine 100mg is to be taken 1 time daily in the AM. Medication Administration Record & the Record of Prescriptions document do not match. March2009 As indicated by the Medication Administration Records the individual is to take Fluvoxamine 100mg (2 times daily). According to the Record of Prescriptions, Fluvoxamine 100mg is to be taken 1 time daily in the AM. Medication Administration Record & the Record of Prescriptions document do not match. April 2009 During on-site survey Medication Administration Records were requested for the month of April 2009. As of June 18, 2009, Medication Administration Records had not been provided. Individual #10 During on-site survey (June 8 - 18, 2009) Physician orders were requested. As of June 18, 2009 Physician orders had not been provided. February 2009 During on-site survey Medication Administration Records were requested for the month of February 2009. As of June 18, 2009, Medication Administration Records had not been provided. Individual #11 During on-site survey (June 8 - 18, 2009) Physician orders were requested. As of June 18, 2009 Physician orders had not been provided.		

	February 2009 Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard: • Fluticasone 120 INH March 2009 Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard: • Fexofenadine 180mg • R-Tanna April 2009 Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard: • Fexofenadine 180mg Individual #12 During on-site survey (June 8 - 18, 2009) Physician orders were requested. As of June 18, 2009 Physician orders had not been provided. February 2009 During on-site survey Medication Administration Records were requested for the month of February 2009. As of June 18, 2009, Medication Administration Records had not been provided. March 2009 During on-site survey Medication Administration Records were requested for the month of March 2009. As of June 18, 2009, Medication Administration Records had not been provided.		

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	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 #3 February 2009 Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 325 or 500mg (PRN) • Pepto Bismol (PRN) • Mylanta (PRN) March 2009 Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 325 or 500mg (PRN) • Pepto Bismol (PRN) • Mylanta (PRN) Individual #6 February 2009 Physician's orders indicated the following medication was to be given. Medication was not documented on the Medication Administration Records for the following medication: • Lorazepam 1mg (2 times daily & PRN) Review of the records found no MAR, but a "Controlled Substance Log." The document did not distinguish between routine & PRN for the following medications: • Lorazepam 1 mg (2 times daily & PRN)		

use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **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	Medication Administration Record document did not contain the following information: the symptoms that indicate the use of the medication. Medication Administration Record document did not contain the following information: the effectiveness that indicate the results of the medication Medication Administration Record document did not contain the following information: the exact amount to be used in a 24-hour period March 2009 Physician's orders indicated the following medication were to be given. Medications were not documented on the Medication Administration Records for the following medication: • Lorazepam 1mg (2 times daily & PRN) Review of the records found no MAR, but a "Controlled Substance Log." The Log did not distinguish between routine & PRN for the following medications: • Lorazepam 1 mg (2 times daily & PRN) Medication Administration Record document did not contain the following information: the symptoms that indicate the use of the medication. Medication Administration Record document did not contain the following information: the effectiveness that indicate the results of the medication Medication Administration Record document did not contain the following information: the exact amount to be used in a 24-hour period April 2009 Physician's orders indicated the following medication were to be given. Medications were		

consanguinity 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.	not documented on the Medication Administration Records for the following medication: • Lorazepam 1mg (2 times daily & PRN) Review of the records found no MAR, but a "Controlled Substance Log." The document did not distinguish between routine & PRN for the following medications: • Lorazepam 1 mg (2 times daily & PRN) Medication Administration Record document did not contain the following information: the symptoms that indicate the use of the medication. Medication Administration Record document did not contain the following information: the effectiveness that indicate the results of the medication Medication Administration Record document did not contain the following information: the exact amount to be used in a 24-hour period Individual #8 February 2009 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Patanol – PRN – 2/1, 4 & 8 (given 1 time daily) March 2009 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Patanol – PRN – 3/2 & 13 (given 1 time daily) • Claritin 10mg – PRN – 3/20 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Patanol – PRN – 3/2 & 13 (given 1 time daily)		

	• Claritin 10mg – PRN – 3/20 (given 1 time daily) Individual #9 February 2009 Medication Administration Record did not contain the signature or initials of individual administering the medication: • Midol 500mg – PRN – 2/1 (given 1 time daily) • Acetaminophen 325 or 500mg – PRN – 2/1 (given 1 time daily) • Sudafed 30mg – PRN – 2/1 (given 1 time daily) Medication Administration Record did not document the exact dosage that was administered: • Acetaminophen 325 or 500mg– PRN – 02/01 (given 1 time daily) March 2009 Medication Administration Record did not document the exact dosage that was administered: • Acetaminophen 325 or 500mg– PRN – 03/22 (given 1 time daily) Individual #10 March 2009 Medication Administration Records did not contain the amount of days the medications was to be given in the course of a month. No Physician's orders were found to determine the amount of days the medication should be administered/assisted with: • Amox-Clav. 2 teaspoons (2 times daily) Individual #11 February 2009 Medication Administration Records do not indicate whether the following medications are		

	Routine or PRN medications and do not include required information as per standard: • Fluticasone 120 INH Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Fexofenadine 180mg (PRN) • Temazepam 15 mg (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Temazepam 15 mg – PRN –2/3, 4 & 5 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Temazepam 15 mg – PRN – 2/3, 4 & 5 (given 1 time daily) March 2009 Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard: • Fexofenadine 180mg • R-Tanna No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Temazepam 15 mg – PRN – 3/16 & 19 (given 1 time daily) • Fexofenadine 180 mg – PRN – 3/20, 21, 22, 23, 24 & 25 (given 1 time daily) No Effectiveness was noted on the Medication		

	Administration Record for the following PRN medication: • Temazepam 15 mg – PRN – 3/16 & 19 (given 1 time daily) • Fexofenadine 180 mg – PRN – 3/20, 21, 22, 23, 24 & 25 (given 1 time daily) April 2009 Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard: • Fexofenadine 180mg No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Temazepam 15 mg – PRN – 4/22, 26 & 28 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Temazepam 15 mg – PRN – 4/22, 26 & 28 (given 1 time daily)		

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. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.	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 7 of 12 individuals. Individual #1 April 2009 • The Agency billed 1 unit of Family Living on 04/05/09. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. • The Agency billed 1 unit of Family Living on 04/11/09. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Individual #5 March 2009 • The Agency billed 1 unit of Family Living on 03/28/09. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. April 2009 • The Agency billed 1 unit of Family Living Service on 04/28/09. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Individual #6 February 2009 • The Agency billed 28 units of Family Living on 02/01/09 through 02/28/09. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. March 2009 • The Agency billed 31 units of Family Living on 03/01//2009 through 03/31/2009. Documentation did not contain a		

	signature/authenticated name of the staff providing the service to justify billing. April 2009 • The Agency billed 30 units of Family Living on 04/01/2009 through 04/30/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. Individual #7 February 2009 • The Agency billed 1 units of Family Living on 02/11/09. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. • The Agency billed 1 units of Family Living on 02/14/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. Individual #10 February 2009 • The Agency billed 28 units of Family Living on 02/01/2009 through 02/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. March 2009 • The Agency billed 31 units of Family Living on 03/01/2009 through 03/31/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. April 2009 • The Agency billed 30 units of Family Living on 04/01/2009 through 04/30/2009. Documentation did not contain a signature/authenticated name of the staff		

	providing the service to justify billing. Individual #11 February 2009 • The Agency billed 28 units of Family Living on 02/01/2009 through 02/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. March 2009 • The Agency billed 31 units of Family Living on 03/01/2009 through 03/31/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. April 2009 • The Agency billed 30 units of Family Living on 04/01/2009 through 04/30/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. Individual #12 February 2009 • The Agency billed 28 units of Family Living on 02/01/2009 through 02/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. March 2009 • The Agency billed 31 units of Family Living on 03/01/2009 through 03/31/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. April 2009 • The Agency billed 30 units of Family Living on 04/01/2009 through 04/30/2009.		

	Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing.		

Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. **(1) Documentation of nursing assessment activities** (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver	Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 9 of 12 individual The following were not found, incomplete and/or not current: • Medication Administration Assessment Tool (#8) • **Quarterly Nursing Review of HCP/Crisis Plans:** ° 5/2008 - 5/2009 (#6) ° 5/2008 - 5/2009 (#7) • **Special Health Care Needs:** • Nutritional Evaluation ° Individual #8 - As indicated by the documentation reviewed, evaluation was completed on 9/26/08. Follow-up was to be completed in 3 months. No evidence of follow-up found. • Nutritional Plan ° Individual #7 - As indicated by the IST section of ISP the individual is required to have a plan. ° Individual #9 - As indicated by the IST section of ISP the individual is required to have a plan. • **Health Care Plans** • Individual #6 - As indicated by the documentation reviewed the individual is a HAT Level 4. According to DD Waiver Standards individuals with HAT scores of 4, 5 & 6 are required to have Health Care Plans, none was found.		

complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request. (c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first. (d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy). (e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as *subjective* information including the individual complaints, signs and symptoms noted by staff, family members or other team members; *objective* information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants. **(2) Health related plans** (a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and	• Constipation ° Individual #9 – Not current. Plan on file expired on 05/30/2009. • Falls ° Individual #9 – Not current. Plan on file expired on 05/30/2009. ° Individual #10 – Not current. Plan on file expired on 10/17/07. • Skin Breakdown ° Individual #10 – Not current. Plan on file expired on 10/17/07. • **Crisis Plans** • Seizures ° Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan. • Allergies ° Individual #7 - As indicated by the IST section of ISP the individual is required to have a plan. ° Individual #12 – As indicated by the IST section of ISP the individual is required to have a plan. • Aspiration ° Individual #12 - As indicated by the IST section of ISP the individual is required to have a plan. • **Abnormal Involuntary Movement Screening and/or Tardive Dyskinesia Screenings** ° None found 05/2008 - 05/2009 (#1) ° None found 05/2008 - 05/2009 (#5) ° None found 05/2008 - 05/2009 (#6)		

intervention plan must be written by the nurse or other appropriately designated healthcare professional. (b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan. (c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. (d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings. **(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):** (a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition. (b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal. (c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family			

members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan. (d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions. (e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings. (f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization. (g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author. (h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed. **(4) General Nursing Documentation** (a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person. (b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.			

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: 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 18 of 21 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • First Aid (DSP #40, 41, 44, 45, 47, 48, 51, 52, 53, 54, 57 & 59) • CPR (DSP #40, 41, 44, 45, 48, 49, 50, 51, 52, 55, 56, 58 & 59) • Assisting With Medications (DSP #44, 49, 50, 51, 52, 55, 56, 57 & 59) • Rights & Advocacy (DSP #56 & 61) • Level 1 Health (DSP #56, 59 & 61) • Teaching & Support Strategies (DSP #56, 59 & 61) • Participatory Communication & Choice Making (DSP #61)		

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	Based on interview, the Agency failed to ensure that training competencies were met for 6 of 12 Direct Service Personnel. When DSP were asked if they received training on the Individual's Crisis Plans, the following was reported: • DSP #40 stated, "No." According to the Agency file, the Individual has Crisis Plans for seizures. (Individual #1) • DSP #45 stated, "No." According to the Agency file, the Individual has Crisis Plans for seizures and diabetes. (Individual #6) • DSP #46 stated, "He doesn't have any crisis plans." According to the Individual Specific Training section of the ISP the individual has crisis plans for gastrointestinal and allergies. • DSP #48 stated, "No." According to the Agency file, the Individual has Crisis Plans for falls and constipation. (Individual #9) When DSP were asked how new staff are trained on what to do if the individual has a seizure, the following was reported: • DSP #40 stated, "Nothing, there is no training." According to the Agency file, the Individual has Crisis Plans for seizures. (Individual #1) When DSP were asked what they are suppose to do if there is a medication error, the following was report • DSP #41 stated, "I would throw the pill away. But I know you are supposed to put in a sealed container and take it to the pharmacy." (Individual #2)		

Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and (5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support. (6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows: (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.	When DSP were asked if the individual took PRN medication, i.e. Aspirin, Tylenol, etc, and how it was documented, the following was reported: • DSP #45 stated, "I was told I didn't have to document that so I don't write it down." (Individual #6) When DSP were asked if they received training on the Individual's Health Care Plans, the following was reported: • DSP #46 stated, "He doesn't have any Health Care Plans." According to the Agency file, the Individual is a HAT score 5 and has Health Care Plans. (Individual #7) When DSP were asked to describe the signs and symptoms of an adverse reaction to a medication, the following was reported: • DSP #50 stated, "Out of control maybe...I don't know." (Individual #11)		

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: E		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:** **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11** **DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **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	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 7 of 24 Agency Personnel. The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings: • #45 – Date of hire 04/26/2007 • #51 – Date of hire 12/01/1999 • #53 – Date of hire 11/01/2004 • #61 – Date of hire 10/27/2006 • #62 – Date of hire unknown. Information requested but not provided during survey. • #63 – Date of hire unknown. Information requested but not provided during survey. • #64 – Date of hire unknown. Information requested but not provided during survey.		

any of the felonies in this subsection. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1.IV. General Provider Requirements.** **D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.			

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E		
NMAC 7.1.12.8 **REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED**: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.	Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 8 of 24 Agency Personnel. The following Agency personnel records contained NO evidence of the Employee Abuse Registry being completed: • #62 – Date of hire unknown. Information requested but not provided during survey. • #63 – Date of hire unknown. Information requested but not provided during survey. • #64 – Date of hire unknown. Information requested but not provided during survey. The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire: • #45 – Date of hire 04/26/2007 • #46 – Date of hire 10/04/2008 • #56 – Date of hire 12/18/2006 • #57 – Date of hire 05/01/2007 • #61 – Date of hire 10/27/2006		

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. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1.IV. General Provider Requirements.** **D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.			

Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	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 10 of 25 Agency Personnel. • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#41, 49, 53, 54, 57, 59, 60, 63 & 64) When DSP were asked to give examples of Abuse, Neglect & Misappropriation of Consumers' Property, the following was reported: • DSP #40 stated, “You got me there.”		

Tag # 1A28 (CoP) Incident Mgt. System - Parent/Guardian Training	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. **E. Consumer and Guardian Orientation Packet:** Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 5 of 12 individuals. • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#1, 2, 5, 6 & 8)		

Tag # 1A28 (CoP) Incident Mgt. System - Posters	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. **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 5 of 12 residences: The following locations were identified: Residence of : • Individual #4 • Individual #5 • Individual #7 • Individual #8 • Individual #9		

Tag # 1A29 Complaints / Grievances - Acknowledgement	Scope and Severity Rating: B		
NMAC 7.26.3.6 A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's complaint or grievance procedure	Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 4 of 12 individuals. • Grievance/Complaint Procedure Acknowledgement (#1, 2, 5 & 6)		

Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: D		
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	Based on record review and interview, the Agency failed to ensure the rights of Individuals was not restricted or limited for 1 of 12 Individuals. (Individual #6) When #65 was asked if the Agency had documentation of Human Rights approval, the following was reported, #65 stated, "We did not review anything for her. I'm not sure we were aware that she was taking any PRN psychotropic medication but we will talk with her mother and review if necessary." A review of Agency Individual files indicated 1 of 12 Individuals required Human Rights Committee Approval for restrictions. No documentation was found regarding Human Rights Approval for the following: • Psychotropic Medications to control behaviors. 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 # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: E		
NMAC **7.26.5.16.C and D** **Development of the ISP. Implementation of the ISP.** The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	Based on record review the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 5 of 12 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes: • None found for 1/2009 (Individual #3) • None found for 4/2008 - 4/2009 (Individual #6) • None found for 9/2008 & 1/2009 (Individual #10) • None found for 5/2008 & 1/2009 (Individual #11) • None found for 1/2009 (Individual #12)		

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 record review and observation, the Agency failed to ensure proper storage of medication for 2 of 12 individuals. **Observation of first aid kit included:** Individual #2 • Tylenol 500mg expired 04/2009. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Motrin 200mg expired 02/2008. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. Individual #4 • Aspirin expired 08/2008. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. **Observation of medication cabinet included:** Individual #2 • Medications were not stored in a locked container. They were kept in a cabinet without a lock. Per Agency Policy all medications are to be kept in a locked container.		

Tag # 1A36 SC Training	Scope and Severity Rating: A		
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 1 of 3 Service Coordinators. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed: • Pre-Service Manual (SC #63)		

Tag # 1A37 Individual Specific Training	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: (2) **Individual-specific training** for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007** **II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications	Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 24 of 24 Agency Personnel. Review of personnel records found no evidence of the following: • Individual Specific Training (#40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63 & 64)		

described in the individual service plan (ISP) of each individual served. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines. F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements. G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques. H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001. I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines			

for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)			

Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: E		
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	Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 6 of 12 individuals. • DDSD Approval for Subcontractor (#3, 6 & 11) • Family Living (Initial) Home Study (#3, 6, 8, 10 & 11) • Family Living (Annual Update) Home Study (#3 & 5) • Current Family Living Contract (#5 & 6)		

standards. (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 # 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	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 12 individuals receiving Community Living Services. • **Annual Physical** (#6) • **Dental Exam** ° Individual #3 - As indicated by the documentation reviewed, the exam was completed 10/2007. No evidence of exam was found. ° Individual #6 - As indicated by the documentation reviewed, exam was completed on 11/10/2008. Follow-up was to be completed in 3 months. No evidence of follow-up found. • **Vision Exam** ° Individual #6 - As indicated by the documentation reviewed, exam was completed on 04/25/2008. Follow-up was to be completed in 1 year. No evidence of follow-up found. ° Individual #11 - As indicated by the documentation reviewed, exam was last completed on 10/04/2005. Follow-up was to be completed ASAP. No evidence of follow-up found. • **Blood Levels** ° Individual #5 - As indicated by the documentation reviewed, labs were ordered on 09/30/2008. No evidence of labs being completed was found.		

Nursing Services. b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse. (c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition. (4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT. (5) That the physical property and grounds are free of hazards to the individual's health and safety. (6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following: (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, 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 12 of 12 Individuals receiving Family Living Services. The following was not found, incomplete and/or not current: • Current Emergency & Personal Identification Information ° Did not contain Pharmacy Information (#1, 2 & 5) • Annual ISP (#3, 6 & 10) • Teaching & Support Strategies (#1, 2, 4, 5, 6, 10 & 11) • ISP Signature Page (#2 & 3) • Addendum A (#2, 3, 4, 6 & 10) • Individual Specific Training (Addendum B) (#3 & 6) • Positive Behavioral Crisis Plan (#4 & 8) • Speech Therapy Plan (#6) • Occupational Therapy Plan (#11) • Physical Therapy Plan (#9) • Health Assessment Tool (#9 & 11) • **Special Health Care Needs** ° Meal Time Plan (#5 & 7) • **Health Care Plans** ° Constipation (#9 & 11)		

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	° Diabetes (#6) ° Falls (#1 & 9) ° Hernia (#11) ° Seizures (#1 & 6) ° Hat Level 4 (#6) ° Required per IST (#7) • **Crisis Plan** ° Allergies (#7) ° Aspiration (#4, 11 & 12) ° Falls (#4) ° GERD (#7) ° Hyperglycemia (#2) ° Seizures (#1, 4 & 5)		

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

Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports)	Scope and Severity Rating: B		
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 7 of 12 individuals receiving Community Living Services. Family Living Quarterly Reports: • Individual #3 - None found for 02/2009 - 04/2009 • Individual #4 - None found for 05/2008 - 06/2009 • Individual #5 - None found for 01/2009 - 03/2009 • Individual #6 - None found for 04/2008 - 04/2009 • Individual #10 - None found for 04/2008 - 09/2008 • Individual #11 - None found for 07/2008 - 03/2009 • Individual #12 - None found for 07/2008 - 12/2008		

Tag # 6L25 (CoP) Residential Health & Safety (Family Living)	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	Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 8 of 12 Family Living residences. The following items were not found, 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 (#7 & 9) • Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#10) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#2, 4, 10 & 11) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#4, 5, 10, 11 & 12)		

hazardous waste spills, and flooding.			

Tag # 6L25 (CoP) Residential Reqts. (Physical Environment)	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** (2) Overall each residence shall maintain basic utilities, i.e., gas, power, water, telephone at the residence and shall maintain the physical environment in a safe and comfortable manner for the individuals. (3) Each individual shall have access to all household equipment and cleaning supplies unless precluded by his or her ISP. (4) Living and Dining Areas shall (a) Provide individuals free use of all space with due regard for privacy, personal possessions and individual interests; (b) Maintain areas for the usual functions of daily living, social, and leisure activities in a clean and sanitary condition; and (c) Provide environmental accommodations based on the unique needs of the individual. (5) Kitchen area shall: (a) Possess equipment, utensils, and supplies to properly store, prepare, and serve at least three (3) meals a day; (b) Arrangements will be made, in consultation with the IDT for environmental accommodations and assistive technology devices specific to the needs of the individual(s); and (c) Water temperature is required to be	Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard, which maintains a physical environment which is safe and comfortable for 1 of 12 Family Living residences. During on-site visit (06/16/2009), surveyors observed the following: Individual's room did not have a door only a curtain to separate it from the living room. When asked the FLP #40 stated, "We are supposed to get a door for her room." (Individual #1)		

maintained at a safe level to both prevent injury and ensure comfort. (6) Bedroom area shall: (a) At a maximum of two (2) individuals share, with mutual consent, a bedroom and each individual has the right to have his or her own bed; (b) All bedrooms shall have doors, which may be closed for privacy (c) Physical arrangement of bedrooms compatible with the physical needs of the individual; and (d) Allow individuals the right to decorate his or her bedroom in a style of his or her choice consistent with a safe and sanitary living conditions. (7) Bathroom area shall provide: (a) For Supported Living, a minimum of one toilet and lavatory facility for every two (2) individuals with Developmental Disabilities living in the home; (b) Reasonable modifications or accommodations, based on the physical needs of the individual (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.): (i) Toilets, tubs, showers used by the individual(s) provide for privacy; designed or adapted for the safe provision of personal care; and (ii) Water temperature maintained at a safe level to prevent injury and ensure comfort.			