Date:	May 10, 2012
To:	Cruz Rojas, Executive Director
Provider:	Grace Requires Understanding, Inc.
Address:	1100 S. Main Suite A
State/Zip:	Las Cruces, NM 88005
E-mail Address:	cmrojas@mygru.org
CC:	Victor Duran, Board Chair
Address:	P. O. Box 2334
State/Zip:	Mesilla Park, NM 88047
E-Mail Address:	victord3@msn.com
Region:	Southwest
Survey Date:	March 5 - 9, 2012
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Living Supports (Family Living & Independent Living) & Inclusion Supports (Adult Habilitation & Community Access)
Survey Type:	Routine
Team Leader:	Valerie V. Valdez, M.S., Health Program Manager, Division of Health Improvement/Quality Management Bureau
Team Members:	Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Mari Chavez, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Cindy Nielsen, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Rojas:

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

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

This determination is based on non compliance with four or more CMS waiver assurances at the Condition of Participation level as well as widespread Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction. Due to repeat non-Compliance your Agency is being referred to the Internal Review Committee.

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

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

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

1. **Quality Management Bureau, Attention: Plan of Correction Coordinator**
   5301 Central Ave. NE Suite 400 Albuquerque, NM 87108

2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.
Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

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

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

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

Please call the Plan of Correction Coordinator at 505-699-0714 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Valerie V. Valdez, M.S.

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

Survey Process Employed:

Entrance Conference Date:	March 5, 2012
Present:	**Grace Requires Understanding, Inc.** Paul Farren, Executive Director **DOH/DHI/QMB** Valerie V. Valdez, M.S., Health Program Manager Mari Chavez, BSW, Healthcare Surveyor
Exit Conference Date:	March 8, 2012
Present:	**Grace Requires Understanding, Inc.** Paul Farren, Executive Director Joanna Tarango, Adult Habilitation Director Cruz Maria Rojas, Family Supports Manager Maria C. Rubio, Family Supports Manager Stacey Fellwock, Nurse Administrator Noel Marquez, Family Supports Manager Mark Chavez, General Manager Virginia Sanchez, Training Coordinator Guadalupe Ordunez, Billing/Training Dolores Ordunez, Office Manager **DOH/DHI/QMB** Valerie V. Valdez, M.S., Health Program Manager Nadine Romero, LBSW, Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor Jennifer Bruns, BSW, Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor Mari Chavez, BSW, Healthcare Surveyor Cindy Nielsen, RN, Healthcare Surveyor **DDSD - SW Regional Office** Scott Doan, SW DDSD Regional Director
Total Homes Visited	Number: 19
❖ Family Homes Visited	Number: 19
Administrative Locations Visited	Number: 2 (1100 S. Main Suite A Las Cruces, New Mexico & #6 Peterson Drive Silver City, New Mexico)
Total Sample Size	Number: 22 0 - *Jackson* Class Members 22 - Non-*Jackson* Class Members 20 - Family Living 2 - Independent Living 14 - Adult Habilitation 13 - Community Access
Persons Served Records Reviewed	Number: 22
Persons Served Interviewed	Number: 13

Persons Served Observed	Number:	9 (5 Individuals were not available during the on-site visits; 2 Individuals chose not to participation in the interview process & 2 other individuals did not answer surveyors questions, but interacted with their DSP during the interviews)
Direct Support Personnel Interviewed	Number:	30
Direct Support Personnel Records Reviewed	Number:	173
Service Coordinator Records Reviewed	Number:	12 (7 Service Coordinators are also Direct Support Personnel)

Administrative Files Reviewed

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

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

Attachment A

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

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

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

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

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

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-699-0714 or email at scott.good@state.nm.us. Requests for technical assistance must be requested through your DDSD Regional Office.

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

Instructions for Completing Agency POC:

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

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

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

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and

sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
6. The POC must be signed and dated by the agency director or other authorized official.

The following details should be considered when developing your POC:

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the QMB Deputy Chief, Scott Good at 505-699-0714 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to Scott Good, QMB Deputy Chief in any of the following ways:
    a. Electronically at scott.good@state.nm.us *(preferred method)*
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approve” or “denied.”

a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.

7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

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

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

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

QMB Determinations of Compliance

- "Compliance with Conditions of Participation"
  The QMB determination of "Compliance with Conditions of Participation," indicates that a provider is in compliance with all 'Conditions of Participation,' (CoP) but may have standard level deficiencies (deficiencies which are not at the condition level) out of compliance. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with *all* Conditions of Participation.

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

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

- "Non-Compliant with Conditions of Participation":
  The QMB determination of "Non-Compliance with Conditions of Participation," indicates a provider is significantly out of compliance with Conditions of Participation and/or has:
  - Four (4) Conditions of Participation out of compliance.
  - Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
  - Any finding of actual harm or Immediate Jeopardy.

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

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

Attachment C

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

Introduction:

Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated "Document Request," or "administrative Needs," etc. forms. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: http://dhi.health.state.nm.us/qmb
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRC process, email the IRF Chairperson, Scott Good at scott.good@state.nm.us for assistance.

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received within 10 business days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed or requested by the survey team.
- Providers must continue to complete their Plan of Correction during the IRF process
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition.
- Providers may not request an IRF to challenge the DHI/QMB determination of compliance or the length of their DDSD provider contract.

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

The IRF Committee will review the request, the Provider will be notified in writing of the ruling; no face-to-face meeting will be conducted.

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

Agency: **Grace Requires Understanding, Inc - Southwest Region**
Program: Developmental Disabilities Waiver
Service: Living Supports (Family Living & Independent Living) & Inclusion Supports (Adult Habilitation & Community Access)
Survey Type: Routine
Date of Survey: **March 5 - 9, 2012**

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A08 Agency Case File	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 22 of 22 individuals. Review of the Agency individual case files found the following items were not found, incomplete, and/or not current: • **Current Emergency & Personal Identification Information** ◦ Did not contain Pharmacy name and phone number (#10 & 13) ◦ Did not contain Health Plan Information (#2, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21 & 22) ◦ Did not contain the Individual's current address & phone number (#10) ◦ Did not contain the Physician's name and phone number (#10) • **Annual ISP** ◦ Not Found (#3)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.	◦ Not Current (#21) • ISP Signature Page (#2, 3, 13 & 22) • Individual Specific Training Section of ISP (#3, 8 & 21) • **ISP Teaching & Support Strategies (TASS)** ◦ *Individual #1 - TASS not found for the following Action Steps:* ➢ Live: "…will register for classes at DACC/NMSU." ➢ Live: "…will attend classes." ◦ *Individual #2 - TASS not found for the following Action Steps:* ➢ Live: "…will practice and develop the math skills necessary for money management." ➢ Relationship/Have Fun: "…will plan activities as necessary." ◦ *Individual #3 - TASS not found for the following Action Steps:* ➢ Work/Education: "…will make item." ◦ *Individual #4 - TASS not found for the following Action Steps:* ➢ Live: "While alone will call her sister to let her know she is safe." ➢ Live: "When…calls her sister 1 time then mom will schedule time alone 2nd time that week." ◦ *Individual #5 - TASS not found for the following Action Steps:* ➢ Develop Relationships/Have Fun: "Collect materials, family and day hab to assist with purchase." ➢ Develop Relationships/Have Fun: "Take pictures with disposable or provider		

NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.	camera (develop pictures as needed)." ◦ *Individual #7 - TASS not found for the following Action Steps:* ➢ Develop Relationships/Have Fun: "…will research places that he would like to visit." ◦ *Individual #9 - TASS not found for the following Action Steps:* ➢ Live: "researches 5 different animals and what it takes to care for them." ➢ Work/Education: "Participates in 4 H events." ➢ Develop Relationships/Have Fun: "Completes her scrap book and presents it to the team." ◦ *Individual #10 - TASS not found for the following Action Steps:* ➢ Work/Education: "…will make purchase of his choice." ➢ Work/Education: "…will document receipt in a book." ◦ *Individual #11 - TASS not found for the following Action Steps:* ➢ Live: "with staff assistance…will get out of one chair and move towards another chair." ➢ Live: "with staff assistance …will indicate when he wants to get up from the floor usually by crawling to the chair. He will then lift himself to his knees then onto the chair. If he appears to be struggling, staff will provide physical assistance." ➢ Work/Education: "staff will encourage…to communicate with his friends." ➢ Develop Relationships/Have Fun: "with staff assistance…will choose a vacation destination."		

	◦ *Individual #12 - TASS not found for the following Action Steps:* ➢ Develop Relationships/Have Fun: "choose a recipe." ◦ *Individual #13 - TASS not found for the following Action Steps:* ➢ Work/Education: "…will use his flash drive or CD to upload or download media with staff assistance." ◦ *Individual #16 - TASS not found for the following Action Steps:* ➢ Work/Education: "Make 10 crafts per holiday." ➢ Work/Education: "Sell my crafts." ➢ Develop Relationships/Fun: "Create a music list." ➢ Develop Relationships/Fun: "Distribute copies of the CD at the birthday bash." ◦ *Individual #17 - TASS not found for the following Action Steps:* ➢ Work/Education: "Make flyers." ➢ Work/Education: "Identify 5 locations." ➢ Work/Education: "Maintain advertising site weekly." ◦ *Individual #18 - TASS not found for the following Action Steps:* ➢ Develop Relationships/Fun: "Learn difference between friend and stranger." ◦ *Individual #19 - TASS not found for the following Action Steps:* ➢ Live: "…will be prompted when to feed her dog." ➢ Live: "…will press button on her cheap talker to call her dog(s)." ➢ Live: "…will press button on her cheap talker to tell dog its time for a treat."		

	➢ Work/Education: "…will choose a transaction to pay for." ➢ Work/Education: "…will pay for transaction." ➢ Develop Relationship/Fun: "…will choose who to greet." ➢ Develop Relationship/Fun: "…will greet others using cheap talker." • Positive Behavioral Plan (#5, 17 & 21) • Positive Behavioral Crisis Plan (#2, 17 & 21) • Speech Therapy Plan (#7 & 20) • Occupational Therapy Plan (#7 & 11) • Physical Therapy Plan (#3 & 19) • Documentation of Guardianship/Power of Attorney (#3, 4, 13, 14 & 21)		

Tag # 1A08.1 Agency Case File - Progress Notes	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (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 9 of 22 Individuals. **Family Living Progress Notes/Daily Contact Logs** • Individual #16 - None found for 11/2011. **Independent Living Progress Notes/Daily Contact Logs** • Individual #2 - None found for 1/1 – 15, 2012. **Adult Habilitation Progress Notes/Daily Contact Logs** • Individual #6 - None found for 11/1 – 14, 2011. • Individual #7 - None found for 1/16 – 31, 2012. • Individual #14 - None found for 1/16 – 31, 2012. • Individual #19 - None found for 11/2011 – 1/2012. • Individual #21 - None found for 11/2011. • Individual #22 - None found for 11/1 – 15 & 12/1 - 15, 2011. **Community Access Progress Notes/Daily Contact Logs** • Individual #2 - None found for 1/1 – 15, 2012. • Individual #7 - None found for 11/2011 – 1/2012. • Individual #18 - None found for 11/2011.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

	• Individual #19 – None found for 11/1 – 29, 2011.		

Tag # 1A32 & 6L14 ISP Implementation	*Condition Level Deficiency*		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 14 of 22 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #15 • None found for 10/2011 & 12/2011. Individual #16 • None found for 11/2011. **Independent Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #17 • None found for 11/2011 – 1/2012. **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #5 • None found for 11/2011 – 1/2012.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	Individual #6 • None found for 11/2011. Individual #7 • None found for 11/2011 – 1/2012. Individual #12 • None found for 11/2011 – 1/2012. Individual #13 • None found for 11/2011 – 1/2012. Individual #18 • No Outcomes or DDSD exemption/decision justification found for Adult Habilitation Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver." Individual #19 • None found for 11/2011 – 1/2012. Individual #21 • None found for 11/2011. **Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • None found for 1/2012. Individual #7 • None found for 11/2011 – 1/2012. Individual #14 • None found for 11/2011 – 12/2011.		

	Individual #22 • No Outcomes or DDSD exemption/decision justification found for Community Access Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver."		

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **E. Provider Agency Reporting Requirements:** All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD.	Based on record review, the Agency failed to complete quarterly reports as required for 7 of 18 individuals receiving Community Inclusion services. **Adult Habilitation Quarterly Reports** • Individual #6 - None found for 3/2011 – 9/2011, 1/2012 & 2/2012. • Individual #8 - None found for 3/2011 – 11/2011. • Individual #14 - None found for 4/2011 – 6/2011. • Individual #16 - None found for 5/2011 – 10/2011. • Individual #18 - None found for 3/2011 – 11/2011. • Individual #19 - None found for 3/2011 – 12/2011. • Individual #21 - None found for 4/2011 – 12/2011. **Community Access Quarterly Reports** • Individual #1 - None found for 12/2011 & 1/2012. • Individual #6 - None found for 3/2011 – 12/2011 & 2/2012. • Individual #22 - None found for 6/2011 – 11/2011. *Note: Agency completes monthly reports.*	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Tag # 5I11.1 Reporting Requirements (CI Quarterly Report Components)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **E. Provider Agency Reporting Requirements:** All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD.	Based on record review, the Agency failed to complete written quarterly status reports in compliance with standards for 8 of 18 individuals receiving Community Inclusion Services. Review of quarterly reports found the following components were not addressed, as required: *Individual #1 - The following components were not found in the Community Access Quarterly Report for 5/2011 – 11/2011:* (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and *Individual #2 & 18 - The following components were not found in the Community Access Quarterly Report for 6/2011 – 1/2012:* (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs;	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

	(7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and *Individual #7, 8 & 19 - The following components were not found in the Community Access Quarterly Report for 9/2011 – 1/2012:* (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and *Individual #13 - The following components were not found in the Community Access Quarterly Report for 10/2011 – 1/2012:* (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as		

	identified in the ISP; and *Individual #20 - The following components were not found in the Community Access Quarterly Report for 12/2011 & 1/2012:* (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and *Note: Agency completes monthly reports.*		

Tag # 6L14 Residential Case File	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 19 of 20 Individuals receiving Family Living Services. The following was not found, incomplete and/or not current: • **Current Emergency & Personal Identification Information** ◦ Did not contain complete Pharmacy Information (#4, 6 & 9) ◦ Did not contain Health Plan Information (#1, 3, 6, 7, 8, 9, 11, 13, 18, 19, 20, 21 & 22) ◦ Did not contain Individual's Address (#4) ◦ Did not contain name and phone number of relatives or guardian or conservator (#9, 11 & 18) • Annual ISP (#3) • Individual Specific Training Section of ISP (#3) • Positive Behavioral Plan (#5, 7 & 10) • Positive Behavioral Crisis Plan (#16) • Speech Therapy Plan (#7, 11 & 20) • Occupational Therapy Plan (#7 & 11) • Physical Therapy Plan (#3 & 19) • Comprehensive Aspiration Risk Management Plan (#3, 15 & 19)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis.	• **Special Health Care Needs** ◦ Meal Time Plan (#5, 6 & 19) ◦ Nutritional Plan (#6, 8, 9 & 15) • **Health Care Plans** ◦ Allergies (#10) ◦ Aspiration (#3, 12 & 16) ◦ Weight/Body Mass Index (BMI) (#4, 6 & 20) ◦ Bowel & Bladder (#1, 10 & 11) ◦ Colostomy/Ileostomy (#3) ◦ Constipation (#16) ◦ Diabetes (#8) ◦ Falls (#4) ◦ GI Constipation Management (#3 & 20) ◦ Oral Care/Hygiene (#4, 20 & 22) ◦ Respiratory (#3) ◦ Risk for Tube Displacement (#3) ◦ Seizures (#3, 11, 12 & 16) ◦ Skin & Wound (#3, 11 & 16) ◦ Trisomy 8 (#9) ◦ Tube Feeding (#3) • **Crisis Plan/Medical Emergency Response Plans** ◦ Allergies (#1) ◦ Anxiety (#6) ◦ Aspiration (#3, 12 & 16) ◦ Body Mass Index (BMI) (#4) ◦ Constipation (#16) ◦ Falls (#4) ◦ GI Constipation Management (#20) ◦ Respiratory (#3) ◦ Risk for Tube Displacement (#3) ◦ Seizures (#3 & 12) ◦ Tube Feeding (#3 & 12) • **Progress Notes/Daily Contacts Logs:** ◦ Individual #3 - None found for 3/1 – 7, 2012. ◦ Individual #4 - None found for 3/1 & 2, 2012.		

(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.	◦ Individual #5 - None found for 3/1 – 7, 2012. ◦ Individual #6 – Documentation for 3/1 – 7, 2012 contained no time in/time out or signatures. ◦ Individual #15 - None found for 3/1 – 6, 2012. ◦ Individual #18 - None found for 3/1 – 7, 2012. ◦ Individual #20 - None found for 3/1 – 7, 2012. ◦ Individual #21 - None found for 3/1 – 6, 2012.		

Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **D. Community Living Service Provider Agency Reporting Requirements:** All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation: (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members.	Based on record review, the Agency failed to complete written quarterly status reports for 9 of 22 individuals receiving Community Living Services. **Family Living Quarterly Reports:** • Individual #9 - None found for 3/2011 - 5/2011 • Individual #11 - None found for 4/2011 – 12/2011. **Family Living Annual Assessment** • Individual #7 - None found for 5/2010 – 5/2011. • Individual #8 - None found for 12/2010 – 11/2011. • Individual #11 - None found for 9/2010 – 9/2011. • Individual #12 - None found for 10/2010 – 10/2011. • Individual #13 - None found for 7/2010 – 7/2011. • Individual #16 - None found for 11/2010 – 11/2011. • Individual #20 - None found for 4/2010 – 4/2012. **Independent Living Quarterly Report:** • Individual #17 - None found for 11/2010 - 11/2011	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A11.1 Transportation Training	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards… **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy** Training Requirements for Direct Service Agency Staff Policy **Eff Date:** March 1, 2007 **II. POLICY STATEMENTS:** I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be	Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 16 of 173 Direct Support Personnel. **No documented evidence was found of the following required training:** • Transportation (DSP #50, 77, 82, 93, 94, 107, 115, 124, 127, 135, 146, 147, 171, 172 & 202) **When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported:** • DSP #126 stated, "No, I did not get trained." • DSP #93 stated, "No."	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

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 # 1A20 Direct Support Personnel Training	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:**	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 44 of 173 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #72, 107, 127, 189 & 202) • Foundation for Health & Wellness (DSP #147 & 189) • Person-Centered Planning (1-Day) (DSP #49, 67, 72, 107, 119, 136, 159 & 189) • First Aid (DSP #50, 54, 63, 66, 88, 89, 115, 118, 131, 141, 166, 175, 176, 196, 205 & 206) • CPR (DSP #45, 50, 54, 66, 83, 88, 115, 118, 131, 148, 161, 164, 166, 170, 175, 176, 191, 196, 205 & 212) • Assisting With Medication Delivery (DSP #72, 86, 87, 107, 115, 135, 141, 175, 189 & 191) • Participatory Communication & Choice Making (DSP #80, 101, 117, 119, 141, 162 & 191) • Advocacy 101 (DSP #119, 141, 147 & 184) • Positive Behavior Supports Strategies (DSP #80, 119, 141, 147 & 184) • Teaching & Support Strategies (DSP #80,	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines. F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements. G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques. H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001. I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.	119, 141, 147, 171 & 184)		

Tag # 1A22 Agency Personnel Competency	*Condition Level Deficiency*		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **F. Qualifications for Direct Service Personnel:** The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency: (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual;	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency failed to ensure that training competencies were met for 21 of 30 Direct Support Personnel. **When DSP were asked what type of Individual Specific Training did they receive to prepare them to work with the individual, the following was reported:** • DSP #189 stated, "I did training with the Case Manager on I don't know what you call it." (Individual #21) **When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported:** • DSP #126 stated, "I don't think so, just the assessment. The plan is not in the file." According to the Individual Specific Training Section of the ISP the Individual requires a Positive Behavioral Supports Plan. (Individual #2) **When DSP were asked if the individual had a Positive Behavioral Crisis Plan and if so, what the plan covered, the following was reported:** • DSP #126 stated, "We have a list of what he has, but I don't see a behavior crisis plan." According to the Individual Specific Training Section of the ISP, the individual has a Positive Behavioral Crisis Plan. (Individual	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and (5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support. (6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows: (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff.**	#2) • DSP #70 stated, "I think it would be in her book, I wouldn't know how to answer that." According to the Individual Specific Training Section of the ISP, the individual has Positive Behavioral Crisis Plan. (Individual #5) • DSP #212 stated, "No." According to the Individual Specific Training Section of the ISP, the individual has Positive Behavioral Crisis Plan. (Individual #16) **When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #57 stated, "Yes, does not have one here." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. DSP was unable to describe what the plan covered (Individual #7) **When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:** • DSP #70 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Seizures & Bowel/Bladder issues. (Individual #5) • DSP #91 stated, "Aspiration." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Weight/ Body Mass Index (BMI), not aspiration. (Individual #6) • DSP #161 stated, "I don't think he does." As indicated by the Electronic Comprehensive		

March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff.	Health Assessment Tool, the Individual requires Health Care Plans for Weight/Body Mass Index (BMI). (Individual #6) • DSP #93 stated, "Falls." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Weight/Body Mass Index (BMI). (Individual #7) • DSP #57 stated, "Falls." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Weight/Body Mass Index (BMI). (Individual #7) • DSP #105 stated, "Aspiration, positioning..." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Bowel & Bladder. (Individual #10) • DSP #199 stated, "No she doesn't have any health care plans." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plan for Tube Feeding, Tube site information, Risk for tube displacement, Aspiration, Seizures, GI/Constipation Management & Skin and Wound. (Individual #12) • DSP #212 stated, "No just the Aspiration HCP for cerebral palsy, but nothing else." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Aspiration, Seizures, GI/Constipation Management & Skin and Wound. (Individual #16) • DSP #171 stated, "No, there should be one, can't find it in the book." As indicated by the		

	Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Weight/Body Mass Index (BMI), Aspiration, Seizures, GI/Constipation Management & Falls. (Individual #18) • DSP #53 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plan for Aspiration, Seizures, GI/Constipation Management & Skin and Wound. (Individual #19) • DSP #211 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plan for Weight/Body Mass Index (BMI), Oral Care/Hygiene & GI/Constipation Management. (Individual #20) • DSP #189 stated, "No. Not that I know of." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan Oral Care/Hygiene. (Individual #21) • DSP #57 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plan for Oral Care/Hygiene. (Individual #22) • DSP #192 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual has a Health Care Plan for Oral Care/Hygiene. (Individual #22) **When DSP were asked if the Individual had a Medical Emergency Response Plans and if**		

	so, what the plan(s) covered, the following was reported: • DSP #93 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Crisis Plans/Medical Emergency Response Plan for Falls. (Individual #7) • DSP #199 stated, "I would call Mr... and 911." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Crisis Plans/Medical Emergency Response Plan for Tube Feeding, Tube site information, Risk for tube displacement, Aspiration & Seizures. (Individual #12) • DSP #127 stated, "I would call the nurse if he were in a crisis and his mother then call 911." As indicated by the ISP section of the ISP, the Individual requires Crisis Plans/Medical Emergency Response Plan for Gastrointestinal. (Individual #13) • DSP #212 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Crisis Plans/Medical Emergency Response Plan for Aspiration, Seizures & GI/Constipation. (Individual #16) • DSP #171 stated, "She carries them in her backpack." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Crisis Plans/Medical Emergency Response Plan for Aspiration, Seizures & Falls. DSP did not elaborate on what the plans were. (Individual #18) • DSP #53 stated, "No." As indicated by the Electronic Comprehensive Health		

	Assessment Tool the Individual requires Crisis Plans/Medical Emergency Response Plan for Aspiration & Seizures. (Individual #19) • DSP #211 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Crisis Plans/Medical Emergency Response Plan for Constipation Management. (Individual #20) **When DSP were asked if the Individual had a person-specific Medical Emergency Response Plan for seizures, the following was reported:** • DSP #212 stated, "No." Per the Electronic Comprehensive Health Assessment Tool, the Individual has a Crisis Plans/Medical Emergency Response Seizures. (Individual #16) • DSP #171 stated, "No. I don't see one in here." Per the Electronic Comprehensive Health Assessment Tool, the Individual has a Crisis Plans/Medical Emergency Response Seizures. (Individual #18) **When DSP were asked what they are to do if an Individual is aspirating (specific to the individual), the following was reported:** • DSP #171 stated, "Do CPR?, don't know what to do." DSP attempted to locate the plan and could not find a plan in the Individual's record. As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual has Individual Specific Crisis Plans/Medical Emergency Response Plan and Healthcare Plans for Aspiration. (Individual #16)		

	When DSP were asked if the Individual had any food and/or medication allergies that could potentially be life threatening, the following was reported: • DSP #120 stated, "No." Per agency documentation reviewed the Individual is allergic to Amoxicillin & Bactrim. (Individual #3) **When DSP were asked what the individual's Diagnosis were, the following was reported:** • DSP #57 stated, "MR I don't know the rest of his." According to the individuals ISP the individual is diagnosed with Autism and Developmental Delay. Staff did not discuss the listed diagnosis. (Individual #7) **When DSP were asked, what are the steps they need to take before assisting an individual with PRN medication, the following was reported:** • DSP #92 stated, "Put on the MAR and call La Clinica de Familia." When asked by Surveyors if they needed to call the Agency nurse, DSP #92 stated, "No." According to DDSD Policy Number M-001 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. (Individual #3) • DSP #171 stated, "Fill out PRN log make sure PRN has doctor's note, fill out the MAR." According to DDSD Policy Number M-001 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. (Individual #18) **When DSP were asked, what steps are you to take in the event of a medication error, the following was reported:** • DSP #63 stated, “”I would throw it away, record it in the MAR and call the doctor.” Per “GRU 504.04 Medication Error Process” DSP are to “…3. Staff will verify medication error and respond by: c. Consult with the pharmacy which dispensed the medication…e. Once the health and safety of the Person Served has been obtained, notify the Service Coordinator or Nurse Administrator, and complete and submit a DHI Incident Report form with 24-hours of incident, according to DHI and GRU Inc policies and procedures.” (Individual #4) • DSP #71 stated, “We have a few seconds or give her another one.” Per “GRU 504.04 Medication Error Process” DSP are to “…3. Staff will verify medication error and respond by: c. Consult with the pharmacy which dispensed the medication…e. Once the health and safety of the Person Served has been obtained, notify the Service Coordinator or Nurse Administrator, and complete and submit a DHI Incident Report form with 24-hours of incident, according to DHI and GRU Inc policies and procedures.” (Individual #15) • DSP #46 stated, Throw it away.” Per “GRU 504.04 Medication Error Process” DSP are to “…3. Staff will verify medication error and		

	respond by: c. Consult with the pharmacy which dispensed the medication…e. Once the health and safety of the Person Served has been obtained, notify the Service Coordinator or Nurse Administrator, and complete and submit a DHI Incident Report form with 24-hours of incident, according to DHI and GRU Inc policies and procedures." (Individual #18)		

Tag # 1A25 Criminal Caregiver History Screening	*Condition Level Deficiency*		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:** **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to maintain documentation indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 16 of 185 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** **Direct Support Personnel (DSP):** • #48 – Date of hire 9/7/2007 • #81 – Date of hire 5/20/2008 • #95 – Date of hire 1/18/2008 • #130 – Date of hire 3/21/2009 • #132 – Date of hire 12/2/2004 • #134 – Date of hire 8/13/2008 • #143 – Date of hire 8/1/2001 • #147 – Date of hire 12/5/2009 • #150 – Date of hire 10/16/2002 • #193 – Date of hire 9/1/2005 • #201 – Date of hire 9/25/2008	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

E. crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.	• #203 – Date of hire 11/9/2010 • #210 – Date of hire 9/7/2007 **Service Coordination Personnel (SC):** • #214 – Date of hire 7/18/2011 • #216 – Date of hire 7/28/2008 • #217 – Date of hire 11/15/2010		

Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	*Condition Level Deficiency*		
NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 18 of 185 Agency Personnel. **The following Agency personnel records contained NO evidence of the Employee Abuse Registry being completed:** **Direct Support Personnel (DSP):** • #81 – Date of hire 5/20/2008. • #95 – Date of hire 1/18/2008. • #122 – Date of hire 3/11/2005. • #132 – Date of hire 12/2/2004. • #140 – Date of hire 10/16/2006. • #147 – Date of Hire 12/15/2009. • #201 – Date of hire 9/25/2008. • #210 – Date of hire 9/7/2007. **Service Coordination Personnel (SC):** • #214 – Date of hire 7/18/2011. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:**	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1.IV. General Provider Requirements. D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider 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.	**Direct Support Personnel (DSP):** • #84 – Date of hire 9/1/2007, completed 3/7/2012. • #89 – Date of hire 1/1/2010, completed 3/31/2010. • #120 – Date of hire 4/25/2011, completed 5/5/2011. • #127 – Date of hire 10/8/2011, completed 1/25/2012 • #149 – Date of hire 9/7/2011, completed 12/27/2011 • #161 – Date of hire 8/8/2011, completed 8/11/2011 • #165 – Date of hire 9/21/2011, completed 9/29/2011 • #180 – Date of hire 12/1/2007, completed 3/7/2012 • #182 – Date of hire 12/1/2007, completed 3/7/2012		

Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency		
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007** **II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-	Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 13 of 185 Agency Personnel. **Direct Support Personnel (DSP):** • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#82, 107, 116, 147, 148, 174, 177 & 181) **Service Coordination Personnel (SC):** • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#52) **When Direct Support Personnel were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect & Misappropriation of Consumers' Property, the following was reported:** • DSP #126 stated, "No, I don't know." Staff was not able to identify the two State Agencies as APS & DHI. • DSP #127 stated, "I don't know the agency names. I go to the GRU to talk to them and send reports to State." Staff was not able to identify the two State Agencies as APS & DHI. • DSP #161 stated, "I forgot." Staff was not able to identify the two State Agencies as APS & DHI. • DSP #189 was not able to identify the two State Agencies as APS & DHI.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

approved incident reporting procedures in accordance with 7 NMAC 1.13.			

Tag # 1A37 Individual Specific Training	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (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	Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 20 of 185 Agency Personnel. Review of personnel records found no evidence of the following: **Direct Support Personnel (DSP):** • Individual Specific Training (#44, 60, 82, 84, 85, 96, 97, 107, 115, 123, 125, 163, 165, 173, 175, 186, 201, 202, 208 & 212)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

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

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 1A03 CQI System	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS** **I. Continuous Quality Management System:** Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and	Based on record review and interview, the Agency failed to implement a complete Continuous Quality Management System. Review of the Agency's Continuous Quality Improvement Plan provided during the on-site survey indicated the agency had a CQI committee which was functional and met regularly. Interview with the Executive Director (#91) and the General Manager (#218) indicated routine peer reviews of Agency files and personnel files. During interviews it was reported that the Agency's Family Support Managers were responsible for CQI of their assigned Family Living Providers and Community Access Personnel. The Adult Hab Manager was responsible for the CQI process as it relates to Adult Habilitation. Yet review of these areas found significant and substantial deficiencies which either were not corrected nor identified.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

coordination of healthcare supports at both supervisory and direct support levels; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction. **7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:** **E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system: **(1)** community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements; **(2)** community based service providers providing developmental disabilities services must have a designated incident management coordinator in place; **(4)** community based service providers providing developmental disabilities services must have an incident management committee to address			

internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.			

Tag # 1A06 Provider Agency Policy & Procedure Requirements	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **B. Provider Agency Policy and Procedure Requirements:** All Provider Agencies, in addition to requirements under each specific service standard shall at a minimum develop, implement and maintain, at the designated Provider Agency main office, documentation of policies and procedures for the following: (1) Coordination of Provider Agency staff serving individuals within the program which delineates the specific roles of agency staff, including expectations for coordination with interdisciplinary team members who do not work for the provider agency; (2) Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated; and (3) Agency protocols for disaster planning and emergency preparedness.	Based on interview, the Agency failed to ensure Agency Personnel were aware of the Agency's On-Call Policy & Procedures for 1 of 30 Agency Personnel. When DSP were asked if the agency had an on-call procedure, the following was reported: • DSP #127 stated, "I would not call GRU because (#135) only wants me to work with him. Call (#135) if an emergency." (Individual #13)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **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;	Medication Administration Records (MAR) were reviewed for the months of December 2011, January & March 2012. Based on record review, 3 of 22 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #6 March 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Probenecid 500mg (1 time daily) • Fluoxetine 20mg (1 time daily) Medication Administration Records did not contain the following medications. Physician's Orders were found for the following medications and the FLP #91 reported that this medication had been replaced another med and it would be corrected on the MAR: • Omeprazole 20mg (1 time daily) Individual #11 December 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Trileptal 225mg (1 time daily) – Blank 12/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21 & 22 (9:30 PM) January 2012 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

(d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug;	• Trileptal 225mg (1 time daily) – Blank 1/14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (9:30 PM) • Trileptal 300mg (1 time daily) – Blank 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 & 12 (9:30 PM) • Nasonex 2 sprays (1 time daily) – Blank 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (7:30 AM) Individual #18 December 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Clonazapam .5mg (2 times daily) – Blank 12/2 & 9 (7 AM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Geodon 80mg (3 times daily) • Geodon 20mg (1 time daily) • Clonazapam .5mg (2 times daily) • Topomax 400mg (1 time daily) • Benadryl 50 (1time daily) Medication Administration Records did not contain the route of administration for the following medications: • Geodon 80mg (3 times daily) • Geodon 20mg (1 time daily) • Clonazapam .5mg (2 times daily)		

(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.	• Topomax 400mg (1 time daily) • Benadryl 50 (1 time daily) Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following: • Geodon 80mg (3 times daily) • Geodon 20mg (1 time daily) • Clonazapam .5mg (2 times daily) • Topomax 400mg (1 time daily) • Benadryl 50 (1 time daily) March 2012 During on-site survey Medication Administration Records were requested for March 1 – 7, 2012. As of the end of the home visit on March 7, 2012 Medication Administration Records had not been provided. When Surveyors asked for the MAR, DSP #46 stated, "I don't know where it's at."		

Tag # 1A09.1 Medication Delivery - PRN Medication	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **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;	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 3 of 22 Individuals. Individual #3 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Alprazalom 0.5mg – PRN – 3/1 & 3 (given 1 time) Individual #9 January 2012 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Ibuprofen 400mg (PRN) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 400mg – PRN – 1/8, 17 & 20 (given 1 time) Individual #11 December 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Diastat 10mg (PRN) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Diastat 10mg – PRN – 12/4, 14 & 30 (given 1 time)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

(d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name;			

(iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period. **Department of Health** **Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006** **F. PRN Medication** 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting,			

diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual. 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:** **Medication Assessment and Delivery**			

Procedure Eff Date: November 1, 2006 C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications). a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).			

Tag # 1A15.2 & 5I09 - Healthcare Documentation	*Condition Level Deficiency*		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. **Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities** (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 18 of 22 individual The following were not found, incomplete and/or not current: • Electronic Comprehensive Health Assessment Tool (e-Chat) (#2 & 13) • Medication Administration Assessment Tool (#16) • Comprehensive Aspiration Risk Assessment Tool (#3, 12, 13 & 19) • Aspiration Risk Management Screening Tool (#21) • Health Passport (#2, 6, 7, 13, 15 & 19) • **Quarterly Nursing Review of HCP/Crisis Plans:** ° None found for 10/2011 – 12/2011 (#11) ° None found for 4/2011 – 12/2011 (#12) ° None found for 11/2011 – 1/2012 (#18) ° None found for 4/2011 – 9/2011 (#19) • **Special Health Care Needs:** • *Meal Time Plan* ° Individual #5 - As indicated by the IST	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request. (c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first. (d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy). (e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as *subjective* information including the individual complaints, signs and symptoms noted by staff, family members or other team members; *objective* information including vital signs, physical 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	section of ISP the individual is required to have a plan. No current plan found. ◦ Individual #12 - As indicated by the IST section of ISP the individual is required to have a plan. No current plan found. • *Nutritional Plan* ◦ Individual #9 - As indicated by the IST section of the ISP the individual is required to have a plan. No evidence of a plan found. ◦ Individual #15 - As indicated by the IST section of the ISP the individual is required to have a plan. No evidence of a plan found. • *Tube Feeding* ◦ Individual #12 - As indicated by the IST section of ISP the individual is required to have a plan. No current plan found. • **Health Care Plans** • *Alcoholism* ◦ Individual #2 - As indicated by the ISP the individual is required to have a plan. No evidence of a plan found. • *Aspiration* ◦ Individual #4 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #10 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.		

health problems and follow up on any recommendations of medical consultants. **(2) Health related plans** (a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional. (b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan. (c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. (d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings. (3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended): (a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.	◦ Individual #12 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #16 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Bi-Polar* Individual #2 - As indicated by the ISP the individual is required to have a plan. No evidence of a plan found. • *Body Mass Index* ◦ Individual #6 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #20 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Bowel & Bladder* ◦ Individual #10 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Colostomy* ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath		

(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**	Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Constipation* ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #12 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #16 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #20 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Hypertension* Individual #2 - As indicated by the ISP the individual is required to have a plan. No evidence of a plan found. • *Oral Care* ◦ Individual #20 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.		

(a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person. (b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **B. IDT Coordination** (1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and (2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan. **Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010**	• *Increased Lipids* Individual #2 - As indicated by the ISP the individual is required to have a plan. No evidence of a plan found. • *Respiratory* ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Seizures* ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Skin & Wound* ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #12 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #16 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *"Trispmy 8" [sic]* Individual #9 - As indicated by the IST section of the ISP the individual is required		

F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911. 5. Emergency contacts with phone numbers. 6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.	to have a plan. No evidence of a plan found. • **Crisis Plans/Medical Emergency Response Plans** • *Aspiration* ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #4 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #16 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Constipation* ◦ Individual #16 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #20 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *GERD* ◦ Individual #17 – As indicated by the IST section of the ISP the individual is required to have a plan. No evidence of a plan		

	found. • *Pressure Ulcer Risk* ◦ Individual #3 – As indicated by the IST section of the ISP the individual is required to have a plan. No evidence of a plan found. • *Respiratory* ◦ Individual #2 - As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Seizures* ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #12 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #19 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.		

Tag # 1A29 Complaints / Grievances - Acknowledgement	Standard Level Deficiency		
NMAC 7.26.3.6 A These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's complaint or grievance procedure	Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 1 of 22 individuals. • Grievance/Complaint Procedure Acknowledgement (#2)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Tag # 1A31 Client Rights/Human Rights	Standard Level Deficiency		
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] **Long Term Services Division** **Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003** **IV. POLICY STATEMENT -** Human Rights	Based on record review, the Agency failed to ensure the rights of Individuals was not restricted or limited for 1 of 22 Individuals. A review of Agency Individual files found no documentation of Positive Behavior Plans and/or Positive Behavior Crisis Plans, which contain restrictions being reviewed at least quarterly by the Human Rights Committee. (#18)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

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

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

Tag # 1A33 Board of Pharmacy - Med Storage	Standard Level Deficiency		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **E. Medication Storage:** 1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee. 2. Drugs to be taken by mouth will be separate from all other dosage forms. 3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature. 4. Separate compartments are required for each resident's medication. 5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day. 6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist. **8. References** A. Adequate drug references shall be available for facility staff **H. Controlled Substances (Perpetual Count Requirement)** 1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance, indicating the following information: a. date	Based on record review and observation, the Agency failed to ensure proper storage of medication for 1 of 19 individuals. Observation included: Individual #18 Topiramate 100mg expired 8/26/2010. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

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

Tag #1A39 Assistive Technology & Adaptive Equipment	Standard Level Deficiency		
CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION **F. Sanitation:** (1) Equipment and utensils shall be kept clean and in good repair; and **7.26.5.13 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - ASSESSMENTS:** **7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS:** Each ISP shall contain: **F. Assistive technology:** Necessary support mechanisms and devices, including the rationale for the use of assistive technology or adaptive equipment when a need has been identified shall be documented in the ISP. The rationale shall include the environments and situations in which assistive technology is used. Selection of assistive technology shall support the individual's independence and functional capabilities in as non-intrusive a fashion as possible. **CHAPTER 5 VI. SCOPE OF SUPPORTED EMPLOYMENT SERVICES** (7) Facilitating job accommodations and use of assistive technology, including the use of communication devices; **CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS** **D. Provider Agency Requirements** (6) Qualification and Competencies for Supported Employment Staff (includes	Based on record review and observation the Agency failed to ensure the necessary support mechanisms and devices, including the rationale for the use of assistive technology or adaptive equipment as in place for 2 of 22 Individuals. **During interviews, DSP were asked if the Individual had any assistive devices or adaptive equipment and was it in functioning order.** • DSP #120 stated, "No." As indicated by the ISP the Individual is to use a "Go Talk 4 device for improved communication." Observation by Surveyor found no evidence of the device. (Individual #5) • DSP #211 stated, "No." As indicated by the ISP the Individual uses an "Activity Dictionary daily." Observation by Surveyor found no evidence of the device. (Individual #20)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

intensive): Qualifications and competencies for staff providing job coaching/consultation services shall, at a minimum, are able to: **CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS** **F. Community Access Services Provider Agency Staff Qualifications and Competencies** (1) Qualifications and Competencies for Community Access Coaches. The Community Access Coach shall, at a minimum, demonstrate the ability to: (q) Communicate effectively with the individual including communication through the use of adaptive equipment and use of a communication dictionary when the individual uses these modes of communication; (j) Communicate effectively with the individual including communication through the use of adaptive equipment as well as the individual's Communication Dictionary, if applicable, at the work site; **CHAPTER 6. II. SCOPE OF COMMUNITY LIVING SERVICES**. **A**. The scope of Community Living Services includes, but is not limited the following as identified by the IDT: (8) Implementation of the ISP, Therapy, Meal-time, Positive Behavioral Supports, Health Care, and Crisis Prevention/Interventions Plans, if applicable; (9) Assistance in developing health maintenance supports, as well as monitoring the effectiveness of such supports;			

(12) Assist the individual as needed, in coordination with the designated healthcare coordinator and others on the IDT, with access to medical, dental, therapy, nutritional, behavioral and nursing practitioners and in the timely implementation of healthcare orders, monitoring and recording of therapeutic plans or activities as prescribed, to include: health care and crisis prevention/ intervention plans; **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **H. Community Living Services Provider Agency Staffing Requirements** **(**1) Community Living Service Staff Qualifications and Competencies: Individuals working as direct support staff and supervisors for Community Living Service Provider Agencies shall demonstrate the following: (b) The ability to assist the individual to meet his or her physical (e.g., health, grooming, toileting, eating) and personal management needs, by teaching skills, providing supports, and building on individual strengths and capabilities; **L. Residence Requirements for Family Living Services and Supported Living Services** (1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has: (5) Kitchen area shall: (b) Arrangements will be made, in consultation with the IDT for environmental accommodations and assistive technology devices specific to the needs of the individual(s); and			

Tag # 6L06 Family Living Requirements	*Condition Level Deficiency*		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES** **A. Support to Individuals in Family Living:** The Family Living Services Provider Agency shall provide and document: (5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include: (a) Review, advise, and prompt the implementation of the individual's ISP Action Plans, schedule of activities and appointments; and (b) Assist with service or support issues raised by the direct support provider or observed by supervisor, service coordinator or other IDT members. **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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to complete all DDSD requirements for approval of each direct support provider for 13 of 20 individuals. The following was not found, not current and/or incomplete: • ***Monthly Consultation with the Direct Support Provider*** ◦ Individual #19 – None found for 11/2011 & 12/2011. • ***Family Living (Annual Update) Home Study*** ◦ Individual #1 - Not Found. ◦ Individual #3 - Not Found. ◦ Individual #4 - Not Found. ◦ Individual #8 - Not Found. ◦ Individual #9 - Not Found. ◦ Individual #11 - Not Found. ◦ Individual #12 - Not Found. ◦ Individual #14 - Not Found. ◦ Individual #19 - Not Found. ◦ Individual #21 - Not Found.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS **D. Scope of DDSD Agreement** (4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite; **NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER** **ELIGIBLE PROVIDERS:** I. **Qualifications for community living service providers:** There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards. (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.	• ***Current Family Living Contract*** ◦ Individual #1 - Not Found. ◦ Individual #4 - Not Found. ◦ Individual #5 - Not Found. ◦ Individual #9 - Not Found. ◦ Individual #10 - Not Found. ◦ Individual #11 - Not Found. ◦ Individual #12 - Not Found. ◦ Individual #19 - Not Found. ◦ Individual #20 - Not Found.		

Tag # 6L13 Community Living Healthcare Reqts.	*Condition Level Deficiency*		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever 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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 18 of 22 individuals receiving Community Living Services. The following was not found, incomplete and/or not current: • **Annual Physical** (#3, 5, 7, 9, 10, 12, 13, 14, 16, 17, 18, 19 & 20) • **Dental Exam** ◦ Individual #2 - As indicated by collateral documentation reviewed, the exam was completed on 1/4/2010 and follow-up on 3/29/2010. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found. ◦ Individual #3 - As indicated by collateral documentation reviewed, the exam was completed on 12/8/2010. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found. ◦ Individual #4 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #5 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse. (c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition. (4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT. (5) That the physical property and grounds are free of hazards to the individual's health and safety. (6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following: (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine). **NMAC 8.302.1.17 RECORD KEEPING AND**	◦ Individual #6 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #9 - As indicated by collateral documentation reviewed, exam was completed on 10/20/2011. Follow-up was to be completed in 3 months. No evidence of follow-up found. ◦ Individual #13 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #17 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #18 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • **Vision Exam** ◦ Individual #3 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #5 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #6 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.		

DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.	◦ Individual #7 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #9 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #10 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #12 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #13 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #14 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #16 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #17 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.		

	◦ Individual #18 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #19 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #20 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #21 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #22 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. • **Blood Levels** ◦ Individual #6 - As indicated by collateral documentation reviewed, lab work was completed on 8/31/2011. No evidence of lab results were found. • **Review of Psychotropic Medication** ◦ Individual #6 - As indicated by collateral documentation reviewed last appointment was completed 6/27/2011. The individual was to follow-up in 4 – 6 weeks. No evidence was found indicating follow-up was completed. • **EKG** ◦ Individual #6 - As indicated by collateral		

	documentation reviewed the Individual's Physician had ordered an EKG on 6/27/2011. No evidence was found indicating exam was completed. • **Abnormal Involuntary Movement Screening and/or Tardive Dyskinesia Screenings** ◦ None found 3/2011 - 2/2012 for Geodon (#10) ◦ None found 3/2011 - 2/2012 for Geodon (#18) ◦ None found 4/2011 - 2/2012 for Geodon (#21)		

Tag # 6L25 Residential Health & Safety (Supported Living & Family Living)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services** (1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has: (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence; (b) General-purpose first aid kit; (c) When applicable due to an individual's health status, a blood borne pathogens kit; (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats; (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone; (f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift; (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but	Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 14 of 19 Family Living residences. The following items were not found, not functioning or incomplete: **Family Living Requirements:** • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#1, 3, 7, 8, 9, 10, 11, 12, 13 & 15) • Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#1) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#1, 3, 4, 7, 8, 9, 11, 12 & 13) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 15, 18 & 22)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

are not limited to, fire, chemical and/or hazardous waste spills, and flooding.			

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Financial Accountability – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver*.			
Tag # 5I36 Community Access Reimbursement	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 7 of 13 individuals. Individual #1 November 2011 • The Agency billed a total of 76 units of Community Access (H2021) from 11/1/2011 through 11/30/2011. Documentation did not contain the required elements on 11/2, 9, 18, 29 & 30. Documentation received accounted for 0 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Documentation contained FLP signature and/or initial daily not the Community Access staff signature. December 2011 • The Agency billed a total of 194 units of Community Access (H2021) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/7, 8, 13, 14, 15, 16 & 30. Documentation received accounted for 0 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Documentation contained FLP signature and/or initial daily not the Community Access staff signature.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS** **G. Reimbursement** (1) Billable Unit**:** A billable unit is defined as one-quarter hour of service. (2) Billable Activities**:** The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan; (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and (c) Non face-to-face hours do not exceed 10% of the monthly billable hours. (3) Non-Billable Activities**:** Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include: (a) Time and expense for training service personnel; (b) Supervision of agency staff;	January 2012 • The Agency billed a total of 278 units of Community Access (H2021) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/3, 5, 6, 13, 14, 15, 28 & 29. Documentation received accounted for 0 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Documentation contained FLP signature and/or initial daily not the Community Access staff signature. Individual #2 November 2011 • The Agency billed a total of 44 units of Community Access (H2021) from 11/16/2011 through 11/30/2011. Documentation received accounted for 20 units. January 2012 • The Agency billed a total of 96 units of Community Access (H2021) from 1/1/2012 through 1/15/2012. No documentation was found to justify 96 units billed. Individual #13 November 2011 • The Agency billed a total of 176 units of Community Access (H2021) from 11/1/2011 through 11/30/2011. Documentation did not contain the required elements on 11/1, 2, 3, 4, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 24, 25, 28, 29 & 30. Documentation received accounted for 0 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Documentation contained FLP		

(c) Service documentation and billing activities; or (d) Time the individual spends in segregated facility-based settings activities.	signature and/or initial daily not the Community Access staff signature. December 2011 • The Agency billed a total of 170 units of Community Access (H2021) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/1, 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 29 & 30. Documentation received accounted for 0 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Documentation contained FLP signature and/or initial daily not the Community Access staff signature. January 2012 • The Agency billed a total of 174 units of Community Access (H2021) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30 & 31. Documentation received accounted for 0 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Documentation contained FLP signature and/or initial daily not the Community Access staff signature. Individual #14 January 2012 • The Agency billed 84 units of Community Access (H2021) from 1/16/2012 through 1/31/2012. Documentation received accounted for 62 units. Individual #18 December 2011		

	• The Agency billed a total of 420 units of Community Access (H2021) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/2, 3, 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 16, 18, 19, 21, 23, 26 & 28. Documentation received accounted for 0 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Documentation contained FLP signature and/or initial daily not the Community Access staff signature. January 2012 • The Agency billed a total of 206 units of Community Access (H2021) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/2, 4, 6, 9, 11, 13, 22, 23, 28, 29 & 31. Documentation received accounted for 0 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Documentation contained FLP signature and/or initial daily not the Community Access staff signature. Individual #19 November 2011 • The Agency billed a total of 22 units of Community Access (H2021) from 11/16/2011 through 11/30/2011. Documentation did not contain the required elements on 11/30. Documentation received accounted for 0 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Documentation contained FLP signature and/or initial daily not the Community Access staff signature.		

	December 2011 • The Agency billed a total of 8 units of Community Access (H2021) from 12/1/2011 through 12/5/2011. Documentation did not contain the required elements on 12/1, 2, 3, 4, 5, 12 & 14. Documentation received accounted for 0 units. The following elements were not met: ➢ No documentation was found for 12/1, 2, 3, 4, & 5. ➢ The signature or authenticated name of staff providing the service. Documentation on 12/12 & 4 contained FLP signature and/or initial daily not the Community Access staff signature. January 2012 • The Agency billed a total of 75 units of Community Access (H2021) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/18, 23, 24 & 25. Documentation received accounted for 0 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Documentation contained FLP signature and/or initial daily not the Community Access staff signature. Individual #20 November 2011 • The Agency billed a total of 184 units of Community Access (H2021) from 11/1/2011 through 11/30/2011. Documentation did not contain the required elements on 11/3, 4, 7, 8, 10, 11, 28 & 29. Documentation received accounted for 12 units. The following element was not met: ➢ The signature or authenticated name of		

	staff providing the service. Documentation for the month of 11/2011 was signed on 11/15 & 30th by the FLP and the Community Access staff documentation was not signed daily. December 2011 • The Agency billed a total of 240 units of Community Access (H2021) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/1, 2, 5, 6, 7, 8, 9, 12, 13, 15, 16, 19, 21, 22, 23, 27, 28, 29 & 30. Documentation received accounted for 20 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Documentation for the month of 12/2011 was signed on 12/15 & 31th by the FLP and the Community Access staff documentation was not signed daily. January 2012 • The Agency billed a total of 130 units of Community Access (H2021) from 1/1/2012 through 1/15/2012. Documentation did not contain the required elements on 1/3, 4, 5, 6, 7, 9, 10, 11, 112, 13 & 14. Documentation received accounted for 0 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Documentation for the month of 1/2012 was signed on 1/15 by the FLP and the Community Access staff documentation was not signed daily.		

Tag # 5I44 Adult Habilitation Reimbursement	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND 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 for Adult Habilitation Services for 7 of 14 individuals. Individual #6 November 2011 • The Agency billed a total of 94 units of Adult Habilitation (T2021) from 11/1/2011 through 11/14/2011. Documentation received accounted for 0 units. The following element was not met: ➢ No documentation found for 11/1 - 14. Individual #7 November 2011 • The Agency billed a total of 288 units of Adult Habilitation (T2021) from 11/1/2011 through 11/15/2011. Documentation received accounted for 264 units. January 2012 • The Agency billed a total of 286 units of Adult Habilitation (T2021) from 1/16/2012 through 1/31/2012. Documentation received accounted for 0 units. The following element was not met: ➢ No documentation found for 1/16 - 31. Individual #13 November 2011 • The Agency billed a total of 134 units of Adult Habilitation (T2021) from 11/1/2011 through 11/15/2011. Documentation received accounted for 124 units. January 2012 • The Agency billed a total of 248 units of Adult Habilitation (T2021) from 1/16/2012	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XVI. REIMBURSEMENT** **A. Billable Unit**. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care. **B. Billable Activities** (1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours. (2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours	through 1/31/2012. Documentation received accounted for 134 units. Individual #14 January 2012 • The Agency billed a total of 48 units of Adult Habilitation (T2021 U2) from 1/16/2012 through 1/31/2012. Documentation received accounted for 0 units. The following elements was not met: ➢ No documentation found for 1/16 - 31. Individual #16 November 2011 • The Agency billed a total of 60 units of Adult Habilitation (T2021 U2) from 11/1/2011 through 11/3/2011. Documentation received accounted for 40 units. Individual #17 November 2011 • The Agency billed a total of 80 units of Adult Habilitation (T2021 U1) from 11/16/2011 through 11/29/2011. Documentation received accounted for 48 units. January 2012 • The Agency billed a total of 264 units of Adult Habilitation (T2021 U1) from 1/16/2012 through 1/31/2012. Documentation received accounted for 240 units. Individual #22 November 2011 • The Agency billed a total of 144 units of Adult Habilitation (T2021) from 11/1/2011 through 11/30/2011. Documentation received accounted for 72 units. The following elements was not met: ➢ No documentation found for 11/1 - 15.		

	December 2011 • The Agency billed a total of 93 units of Adult Habilitation (T2021) from 12/1/2011 through 12/31/2011. Documentation received accounted for 72 units. The following elements was not met: ➢ No documentation found for 12/1 - 15.		

Tag # 6L27 Family Living Reimbursement	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND 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 for Family Living Services for 20 of 20 individuals. **Individual #1** November 2011 • The Agency billed a total of 25 units of Family Living (T2033) from 11/1/2011 through 11/25/2011. Documentation did not contain one or more of the required elements on 11/1 – 25, 2011. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1 – 9; 11/11 – 16; 11/18 – 25. ➢ The signature or authenticated name of staff providing the service. Daily documentation contained only initials. December 2011 • The Agency billed a total of 15 units of Family Living (T2033) from 12/1/2011 through 12/15/2011. Documentation did not contain one or more of the required elements on 12/1 – 15, 2011. Documentation received accounted for 0 units. One or more of the following	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES** B. Reimbursement for Family Living Services (1) Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year. (2) Billable Activities shall include: (a) Direct support provided to an individual in the residence any portion of the day; (b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and (c) Any other activities provided in accordance with the Scope of Services. (3) Non-Billable Activities shall include: (a) The Family Living Services Provider Agency may not bill the for room and board; (b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and (c) Family Living services may not be billed for the same time period as Respite. (d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one midnight to the following midnight. Developmental Disabilities (DD) Waiver	elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/3 – 8; 12/10 & 11. ➢ The signature or authenticated name of staff providing the service. Daily documentation contained only initials. • The Agency billed a total of 7 units of Family Living (T2033) from 12/23/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/23 - 29, 2011. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/20, 21, 24 – 29 & 31. ➢ The signature or authenticated name of staff providing the service. Daily documentation contained only initials.		

Service Standards effective 4/1/2007 - **Chapter 6 - COMMUNITY LIVING SERVICES** **III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES** **C. Service Limitations**. Family Living Services cannot be provided in conjunction with any other Community Living Service, Personal Support Service, Private Duty Nursing, or Nutritional Counseling. In addition, Family Living may not be delivered during the same time as respite; therefore, a specified deduction to the daily rate for Family Living shall be made for each unit of respite received. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **DEFINITIONS** **SUBSTITUTE CARE** means the provision of family living services by an agency staff or subcontractor during a planned/scheduled or emergency absence of the direct service provider. **RESPITE** means a support service to allow the primary caregiver to take a break from care giving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.	January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/31; 1/1, 2, 7, 8, 10, 16, 20, 21, 22, 23, 24, 25, 26, 27, 30 & 31. ➢ The signature or authenticated name of staff providing the service. Daily documentation contained only initials. ➢ Services were provided concurrently with another service. 1/21, 22, 23 documentation states, "Spent all day and night with SC provider." **Individual #3** November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each		

	service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1, 3, 4, 8, 11, 15 & 25. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1, 2, 6, 7, 8, 15, 16, 19, 20, 22, 25, 27, 28 & 29. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following element was not met:		

	➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/31; 1/1, 2, 4, 5, 6, 11, 12, 13, 15, 16, 17, 18, 19, 20, 22, 23, 26, 27 & 30. **Individual #4** November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1 – 30, 2011. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011.		

	Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1 -31, 2012. **Individual #5** November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required		

	elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following elements were not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1 – 30, 2011. ➢ Services were provided concurrently with another service. 11/5 documentation states, "w/RP." December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following elements were not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. ➢ Services were provided concurrently		

	with another service. 12/17 & 31 documentation states, "w/RP." January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1 - 31, 2012. **Individual #6** November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following elements were not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living		

	services and/or if the Individual was receiving another DDW service on 11/1 – 30, 2011. ➢ The signature or authenticated name of staff providing the service on 11/30. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following elements were not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which stated, "Person served was in my presence on		

	this day." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1 - 31, 2012. ➢ The signature or authenticated name of staff providing the service from 1/1 – 31/2012. Document was signed one time at the end of the month. **Individual #7** November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1 – 30, 2011. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following element was not met:		

	➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1 - 31, 2012. **Individual #8** November 2011 • The Agency billed a total of 16 units of Family Living (T2033) from 11/1/2011 through 11/9/2011 and 11/24/2011 – 11/30/2011. Documentation did not contain one or more of the required elements on these dates. Documentation received		

	accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1, 3, 4, 5, 8, 9, 24, 25 & 26. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 16, 17, 18, 19, 21, 22, 23, 24, 25, 28 & 29. 2011. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not		

	contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1, 3, 5, 6, 7, 8, 13, 14, 15, 18, 19, 20, 22, 26, 27 & 29. **Individual #9** November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following elements were not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1 – 30, 2011. ➢ The signature or authenticated name of staff providing the service on 11/10, 14,		

	15, 16, 17, 18, 20, 21, 22, 24, 27 & 30. Dates only contained initials. ➢ A description of what occurred during the encounter or service interval. The agencies daily documentation ("Monthly Activity Calendar") for 11/1, 2 & 3. dates were blank. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following elements were not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. ➢ A description of what occurred during the encounter or service interval. The agencies daily documentation ("Monthly Activity Calendar") for 12/1 & 2 were blank. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012.		

	Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which stated, "Person served was in my presence on this day." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 21, 22, 28 & 29, 2012. ➢ The signature or authenticated name of staff providing the service on 1/1, 2, 3, 5 - 31. Dates only contained initials. No signature was noted on 1/4. **Individual #10** November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1 – 30, 2011.		

	➢ The signature or authenticated name of staff providing the service. None found on 11/14 & 22. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following elements were not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the		

	individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1 - 31. ➢ The signature or authenticated name of staff providing the service. No signature was noted on 1/19. ➢ A description of what occurred during the encounter or service interval. The agencies daily documentation ("Monthly Activity Calendar") for 1/31 was blank. **Individual #11** November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1 – 30, 2011. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011.		

	Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1 - 31. Individual #12 November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required		

	elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1 – 30, 2011. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required		

	elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1 - 31. **Individual #13** November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Document only contained staff initials. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Document only contained staff initials.		

	January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following element was not met: ➢ The signature or authenticated name of staff providing the service. Document only contained staff initials on 1/1 – 29. On 1/30 no signature was found. ➢ A description of what occurred during the encounter or service interval. The agencies daily documentation ("Monthly Activity Calendar") for 1/31 was blank. **Individual #14** November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1 – 30, 2011.		

	December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1 - 31.		

	Individual #15 November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following elements were not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1 – 30, 2011. ➢ The signature or authenticated name of staff providing the service. Documentation contained no signature on 11/1. ➢ A description of what occurred during the encounter or service interval on 11/4, 5, 6, 18 & 19. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following elements were not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation		

	contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. ➢ A description of what occurred during the encounter or service interval on 12/2, 3, 17 & 19. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following elements were not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1 - 31. ➢ A description of what occurred during the encounter or service interval on 1/1, 7, 8, 14, 21 & 28. **Individual #16** November 2011 • The Agency billed a total of 28 units of		

	Family Living (T2033) from 11/3/2011 through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following element was not met: ➢ No documentation found for 11/3 – 30, 2011. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for		

	each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1 - 31. **Individual #18** November 2011 • The Agency billed a total of 18 units of Family Living (T2033) from 11/1/2011 through 11/18/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/18/2011. Documentation received accounted for 0 units. The following elements were not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1 – 30, 2011. ➢ The signature or authenticated name of staff providing the service. Documentation contained no signature from 11/1 - 30. ➢ A description of what occurred during the encounter or service interval on 11/5, 6 & 12. December 2011 • The Agency billed a total of 28 units of		

	Family Living (T2033) from 12/2/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/2/2011 – 12/29/2011. Documentation received accounted for 0 units. The following elements were not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. ➢ The signature or authenticated name of staff providing the service. Documentation contained no signature from 12/1 - 29. ➢ A description of what occurred during the encounter or service interval on 12/17 & 29. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to		

	11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1 - 31. ➢ The signature or authenticated name of staff providing the service. Documentation contained no signature 12/30 & 31, 2011 & 1/1 - 31. ➢ A description of what occurred during the encounter or service interval on 12/30. **Individual #19** November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1 – 30, 2011. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not		

	contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1 - 31. **Individual #20** November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011		

	through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1 – 30, 2011. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011		

	through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1 - 31. ➢ A description of what occurred during the encounter or service interval on 1/2. **Individual #21** November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1 – 30, 2011.		

	December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/1 – 29, 2011. January 2012 • The Agency billed a total of 24 units of Family Living (T2033) from 12/30/2011 through 1/23/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/23/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1 - 23.		

	Individual #22 November 2011 • The Agency billed a total of 30 units of Family Living (T2033) from 11/1/2011 through 11/30/2011. Documentation did not contain one or more of the required elements on 11/1/2011 – 11/30/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 11/1, 2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28 & 30, 2011. December 2011 • The Agency billed a total of 29 units of Family Living (T2033) from 12/1/2011 through 12/29/2011. Documentation did not contain one or more of the required elements on 12/1/2011 – 12/29/2011. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living		

	services and/or if the Individual was receiving another DDW service on 12/1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14,1 5, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26 & 28, 2011. January 2012 • The Agency billed a total of 33 units of Family Living (T2033) from 12/30/2011 through 1/31/2012. Documentation did not contain one or more of the required elements on 12/30/2011 – 1/31/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Documentation contained a pre-printed check box for each day of the month, which indicated services were provided from "12 AM to 11:59 PM FL Service." Documentation was not specific to whether the individual was receiving Family Living services and/or if the Individual was receiving another DDW service on 12/30 & 31, 2011 & 1/1, 2, 3, 4, 7, 8, 9, 10, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 28, 29, 30 & 31.		