



Alfredo Vigil, MD
Secretary

DEPARTMENT OF

Building a Healthy New Mexico!

Bill Richardson, Governor

Katrina Hotrum
Deputy Secretary

Jessica Sutin
Deputy Secretary

Michael Mulligan
Acting Deputy Secretary

Karen Armitage, MD
Chief Medical Officer

Date: July 13, 2010

To: Melissa McCue, Executive Director
Provider: Imagine, LLC.
Address: 3909 Juan Tabo Ave. NE Suite 2
State/Zip: Albuquerque, New Mexico 87111

E-mail Address: mmccue@imagineabq.org

CC: Dr. Arminder Kaur, DOM, Chairperson
Address: 11705 Sky Valley Rd.
State/Zip: Albuquerque, New Mexico 8771

Boardchair
E-Mail Address: arminder18@msn.com

Region: Metro
Survey Date: June 7 - 9, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation & Community Access)

Survey Type: Routine
Team Leader: Crystal Lopez-Beck, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Cynthia Nielsen, MSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Stephanie Martinez de Berenger, MPA, GCDF, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. McCue,

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

Quality Management Approval Rating:

The Division of Health Improvement is issuing your agency a determination of "Non-Compliance with Conditions of Participation."

Plan of Correction:

The attached Report of Findings identifies deficiencies found during your agency's survey. You are required to complete and implement a Plan of Correction (POC). Please submit your agency's Plan of Correction (POC) in the



"Assuring safety and quality of care in New Mexico's health facilities and community-based programs."

David Rodriguez, Division Director • Division of Health Improvement

Quality Management Bureau • 5301 Central Ave. NE Suite 400 • Albuquerque, New Mexico 87108
(505) 222-8623 • FAX: (505) 222-8661 • <http://dhi.health.state.nm.us>

DHI Quality Review Survey Report – Imagine, LLC - Metro- June 7 - 9, 2010

Survey Report #: Q10.04.94624542.METRO.001.RTN.02

space on the two right columns of the Report of Findings. See attachment A for additional guidance in completing the POC. The response is due to the parties below within 10 working days of the receipt of this letter:

1. Quality Management Bureau, Attention: Plan of Correction Coordinator
5301 Central Ave. NE Suite 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 within 45 working days. If your plan of correction is denied, you must resubmit a revised plan ASAP for approval. All remedies must still be completed within 45 working days of the original submission.

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

Request for Informal Reconsideration of Findings (IRF):

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

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

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

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

Please call the Team Leader at 505-699-9356, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Crystal Lopez-Beck, BA

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

Survey Process Employed:

Entrance Conference Date: June 7, 2010

Present:

Imagine, LLC

Harcharan Singh, Human Resources

Annette Padilla, LPN

Melissa McCue, Executive Director

DOH/DHI/QMB

Crystal Lopez-Beck, BA, Team Lead/Healthcare Surveyor

Stephanie Martinez de Berenger, MPA, GCDF, Healthcare Surveyor

Cynthia Nielsen, MSN, Healthcare Surveyor

Nadine Romero, LBSW, Healthcare Surveyor

Exit Conference Date: June 9, 2010

Present:

Imagine, LLC

Harcharan Singh, Human Resources

Annette Padilla, LPN

Melissa McCue, Executive Director

Victoria Sanchez, Program Coordinator

Jerry Kay, QA Coordinator

Leo Jerro, Program Advocate

Jerry Mizrahi, CS Director

Julie Castillo, Service Coordinator

Chaundelle Marquez, Program Advocate

Mary Magnusson, RN

Monica Johnson, Service Coordinator

DOH/DHI/QMB

Crystal Lopez-Beck, BA, Team Lead/Healthcare Surveyor

Cynthia Nielsen, MSN, Healthcare Surveyor

Homes Visited

Number: 11

Administrative Locations Visited

Number: 1

Total Sample Size

Number: 12
2 - Jackson Class Members
10 - Non-Jackson Class Members
7 - Supported Living
5 - Family Living
6 - Adult Habilitation
1 - Community Access

Persons Served Interviewed

Number: 8

Persons Served Observed

Number: 4 (Individuals were unavailable during the on-site week)

Records Reviewed (Persons Served)

Number: 12

Administrative Files Reviewed

- Billing Records
- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records

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

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

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8647.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency (“Responsible Party”), and by WHEN (“Date Due”).
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues to prevent the Deficiency from reoccurring, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency’s Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to George.Perrault@state.nm.us, by fax (505-222-8661), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been “Approved” or “Denied”.
- Whether your POC is “Approved” or “Denied”, you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is “Denied” it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8647 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.
- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by-case basis.
- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual numbers.
- Do not submit original documents, hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

Key to Scope scale:

Isolated:

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

Pattern:

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

Widespread:

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

Key to Findings:

“Substantial Compliance with Conditions of Participation”

The QMB determination of “Substantial Compliance with Conditions of Participation” indicates that a provider is in substantial compliance with all ‘Conditions of Participation’ and other standards and regulations. 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 Substantial Compliance with Conditions of Participation, the provider must not have any findings that meet the thresholds for determining non-compliance with any Condition of Participation.

“Non-Compliance with Conditions of Participation”

The QMB determination of “Non-Compliance with Conditions of Participation” indicates that a provider is out of compliance with one (1) or more ‘Conditions of Participation.’ This non-compliance, if not corrected, is likely to result in a serious negative outcome or the potential for more than minimal harm to individuals’ health and safety.

Providers receiving a repeat determination of Non-Compliance may be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

“Sub-Standard Compliance with Conditions of Participation”:

The QMB determination of “Sub-Standard Compliance with Conditions of Participation” indicates a provider is significantly out of compliance with Conditions of Participation and/or has:

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.

Providers receiving a repeat determination of 'Substandard Compliance' will be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

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

Introduction:

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

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

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

The following limitations apply to the IRF process:

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

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

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

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

Agency: Imagine, LLC - Metro Region
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation & Community Access)
Monitoring Type: Routine Survey
Date of Survey: June 7 - 9, 2010

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A08 Agency Case File - Progress Notes	Scope & Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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.</p> <p>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:</p> <p>(3) Progress notes and other service delivery documentation;</p>	<p>Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 1 of 12 Individuals.</p> <p>Adult Habilitation Progress Notes/Daily Contact Logs</p> <ul style="list-style-type: none"> Individual #1 - None found for 02/2010 - 03/2010. When Surveyors requested the progress notes for the above listed months, Surveyors were told by Executive Director #99 that Individual #1 had not received Adult Habilitation Services with Imagine, LLC for the months of February, March & April 2010. Nevertheless, during the reconciling of billing it was found that Adult Habilitation Services were billed for the months in question. 		

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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.</p> <p>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.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <ol style="list-style-type: none"> 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; Prescribed dosage, frequency and method/route of administration, times and dates of administration; Initials of the individual administering or assisting with the medication; Explanation of any medication irregularity; Documentation of any allergic reaction or adverse medication effect; and 	<p>Medication Administration Records (MAR) were reviewed for the months of February, March & April 2010.</p> <p>Based on record review, 7 of 12 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #1 March 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> Abilify 2mg (1 time daily) Amlodipine 5mg (1 time daily) Amlodipine 10mg (1 time daily) <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> Omeprazole 40mg (1 time daily) – Blank 02/05 & 19 (7 PM) <p>Individual #2 February 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> Albuterol .83mg/ml (3 times daily) – Blank 02/24 & 25 (12 PM) <p>Individual #3 February 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> Alendronate Sodium 70mg (1 time daily) 	

<p>(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.</p> <p>(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;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(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 administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (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 	<p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Citalopram 20mg (1 time daily) – Blank 02/05 (8 AM) • Nystatin 100,000 unit (3 times daily) - Blank 06/05 (8 AM) <p>March 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Alendronate Sodium 70mg (1 time daily) • Cephalexin 500mg (2 times daily) • Furosemide 20mg (1 time daily) <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Lacri-Lupe S.O.P. Ointment (1 time daily) – Blank 03/19 (bedtime) <p>April 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Alendronate Sodium 70mg (1 time daily) • Nitrofurantion-Macro 100mg (2 times daily) <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Calcium with Vitam D 600mg/400U (3 times daily) – Blank 04/24 (noon) • Diazepam 2mg (2 times daily) - Blank 04/24 (5 PM) 		
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<p>administering medications.</p> <p>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.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> ➤ 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. 	<ul style="list-style-type: none"> • Isosorbide DN 10mg (2 times daily) - Blank 04/24 (5 PM) • Metoprolol Succ. ER 200mg (2 times daily) - Blank 04/24 (5 PM) • Vitamin C 500mg (2 times daily) - Blank 04/24 (5 PM) • Bisacodyl 10mg (1 time every other day) - Blank 04/30 (PM) • Clotrimazole 1% Cream (2 times daily) - Blank 04/26 (8 AM) <p>Individual #4 April 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Docusate Sodium 100mg (2 times daily) – Blank 04/27 (8 PM) <p>Individual #5 February 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Mirtazapine 15mg (1 time daily) – Blank 02/25 (7 PM) <p>April 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Acyclovir 200mg (3 times daily) <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Clonazepam 0.5mg (1 time daily) – Blank 04/01 (9 PM) 		
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	<ul style="list-style-type: none"> • Docusate Sodium 150mg/18ml (1 time daily) - Blank 04/01 (9 PM) <p>Individual #7 April 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Mineral Oil OTC (1 time a week) – Blank 04/04, 11, 18 & 25 (8 PM) <p>Individual #9 March 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Clonazepam 0.5mg (1 time daily) – Blank 03/06 & 31 (8 PM) <p>April 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Clonazepam 0.5mg (1 time daily) – Blank 04/29 (8 PM) 		
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Tag # 1A09 Medication Delivery - PRN Medication	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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.</p> <p>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.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <ol style="list-style-type: none"> 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; Prescribed dosage, frequency and method/route of administration, times and dates of administration; Initials of the individual administering or assisting with the medication; Explanation of any medication irregularity; Documentation of any allergic reaction or adverse medication effect; and 	<p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 6 of 12 Individuals.</p> <p>Individual #1 February 2010 No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Tylenol 325mg – PRN – 02/15, 16,17 & 26 (given 1 time) <p>April 2010 No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Tylenol 325mg – PRN – 04/29 (given 2 times); 04/19, 04/26 & 04/30 (given 1 time) • Hydrocodone 500mg - PRN - 04/30 (given 1 time) <p>Individual #3 March 2010 No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Tylenol 500mg – PRN – 03/15 & 22 (given 1 time) <p>April 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Acetaminophen 325mg – PRN – 04/14 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN</p>		

<p>(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.</p> <p>(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;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(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 administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (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 	<p>medication:</p> <ul style="list-style-type: none"> • Acetaminophen 325mg – PRN – 04/14 (given 1 time) <p>Individual #4 February 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Acetaminophen 325mg – PRN – 02/18, 19 & 20 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Acetaminophen 325mg – PRN – 02/18, 19 & 20 (given 1 time) <p>March 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Pepto OTC – PRN – 03/05 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Pepto OTC – PRN – 03/05 (given 1 time) <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Pepto OTC (PRN) <p>Individual #8 March 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Acetaminophen 325mg – PRN – 03/11 (given 1 time) 	
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<p>or changed;</p> <p>(x) The name and initials of all staff administering medications.</p> <p>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.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> ➤ 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. <p>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.</p>	<p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Acetaminophen 325mg – PRN – 03/11 (given 1 time) <p>Individual #10 March 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Etodolac 200mg – PRN – 03/12 & 15 (given 1 time) • Ibuprofen 800mg - PRN - 03/10 (given 2 times) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Etodolac 200mg – PRN – 03/12 & 15 (given 1 time) • Ibuprofen 800mg - PRN - 03/10 (given 2 times) <p>April 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Etodolac 200mg – PRN – 04/25 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Etodolac 200mg – PRN – 04/25 (given 1 time) <p>Individual #11 April 2010 No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Pepto Bismol OTC – PRN – 04/28 (given 2 times) 		
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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 # 1A20 DSP Training Documents	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>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.</p> <p>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</p> <p>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</p> <p>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:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 28 of 56 Direct Service Personnel.</p> <p>Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> • Pre- Service (DSP #46 & 95) • Basic Health/Orientation (DSP #41, 42, 46, 53, 55, 63, 66, 76, 83 & 87) • Person-Centered Planning (1-Day) (DSP #53, 55 & 56) • First Aid (DSP #41, 44, 47, 62, 69 & 85) • CPR (DSP #41, 44, 51, 60, 74 & 81) • Assisting With Medication Delivery (DSP #64, 77, 79, 91 & 94) • Level 1 Health (DSP #51, 73, 93 & 94) • Positive Behavior Supports Strategies (DSP #51, 73 & 93) • Participatory Communication & Choice Making (DSP #73 & 93) 		

individual service plan (ISP) of each individual served.

C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.

D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.

E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.

F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.

G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.

H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.

I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services.

Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: E		
<p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>A. Duty To Report:</p> <p>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</p> <p>(2) All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:</p> <p>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</p> <p>(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.</p> <p>(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.</p> <p>B. Notification: (1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.</p>	<p>Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 4 of 14 individuals.</p> <p>Individual #2</p> <ul style="list-style-type: none"> • Incident date 09/23/2009. Allegation was Abuse & Neglect. Incident report was received 09/24/2009. Failure to Report. IMB Late & Failure Report indicated incident of Abuse & Neglect was "Confirmed." <p>Individual #5</p> <ul style="list-style-type: none"> • Incident date 10/31/2009. Allegation was Neglect. Incident report was received 12/07/2009. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." <p>Individual #13</p> <ul style="list-style-type: none"> • Incident date 10/31/2009. Allegation was Neglect. Incident report was received 11/03/2009. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." <p>Individual #14</p> <ul style="list-style-type: none"> • Incident date 10/31/2009. Allegation was Neglect. Incident report was received 11/05/2009. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." 		

Tag # 1A27 (CoP) Duty to Report - IR's Filed During On-Site and/or IR's Not Reported by Provider	Scope and Severity Rating: D		
<p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>A. Duty To Report:</p> <p>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</p> <p>(2) All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:</p> <p>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</p> <p>(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.</p> <p>(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.</p> <p>B. Notification:</p> <p>(1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website; http://dhi.health.state.nm.us/elibrary/ironline/ir.php</p>	<p>During the on-site survey June 7 - 9, 2010, surveyors observed the following incident:</p> <p>During a home visit with Individual #10, surveyors noticed the smell of alcohol in the Individual's home.</p> <p>As a result of what was observed the following incident(s) was reported:</p> <p>Individual #10</p> <ul style="list-style-type: none"> • Incident date 06/08/2010 (3 PM). It was reported on a Department of Health Incident Report (IR) that the consumer's home smelled of alcohol. Incident report was filed. 		

or may be obtained from the department by calling the toll free number.

(2) Division Incident Report Form and Notification by Community Based Service Providers:

The community based service provider shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide. The community based service provider shall ensure all incident report forms alleging abuse, neglect or misappropriation of consumer property submitted by a reporter with direct knowledge of an incident are completed on the division's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The community based service provider shall ensure that the reporter with the most direct knowledge of the incident prepares the incident report form.

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: D		
<p>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.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<p>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 2 of 12 individuals.</p> <p>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #10</p> <ul style="list-style-type: none"> • 51 out of 60 days (85%) of “Imagines Day Habilitation Program Activity Documentation” from 02/2010 through 04/2010 indicated #10 “Slept” or “Watched TV in his room”. Documentation did not indicate that staff was actively trying to engage Individual #10 to participate in Day Habilitation Activities and Outcomes. <p>Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #9</p> <ul style="list-style-type: none"> • None found for 02/2010 - 04/2010 		

Tag # 1A33 Board of Pharmacy - Lic	Scope and Severity Rating: A		
<p>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual</p> <p>6. Display of License and Inspection Reports</p> <p>A. The following are required to be publicly displayed:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Current Custodial Drug Permit from the NM Board of Pharmacy <input type="checkbox"/> Current registration from the consultant pharmacist <input type="checkbox"/> Current NM Board of Pharmacy Inspection Report 	<p>Based on observation, the Agency failed to provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 1 of 7 residences:</p> <p>Individual Residence:</p> <ul style="list-style-type: none"> • Current Custodial Drug Permit from the NM Board of Pharmacy (#8) • Current NM Board of Pharmacy Inspection report (#8) 		

Tag # 5I36 CA Reimbursement	Scope and Severity Rating: C		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 XI. COMMUNITY ACCESS</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 1 of 1 individual.</p> <p>Individual #9 February 2010</p> <ul style="list-style-type: none"> • The Agency billed 36 units of Community Access from 02/01/2010 through 02/07/2010. Documentation received accounted for 6 units. <p>March 2010</p> <ul style="list-style-type: none"> • The Agency billed 36 units of Community Access from 03/01/2010 through 03/07/2010. Documentation received accounted for 22 units. • The Agency billed 36 units of Community Access from 03/08/2010 through 03/14/2010. Documentation received accounted for 20 units. • The Agency billed 36 units of Community Access from 03/15/2010 through 03/21/2010. Documentation received accounted for 22 units. • The Agency billed 36 units of Community Access from 03/22/2010 through 03/28/2010. Documentation received accounted for 20 units. <p>April 2010</p> <ul style="list-style-type: none"> • The Agency billed 35 units of Community Access from 03/29/2010 through 04/04/2010. Documentation received accounted for 22 units. • The Agency billed 35 units of Community Access from 04/05/2010 through 04/11/2010. Documentation received accounted for 22 units. • The Agency billed 35 units of Community Access from 04/12/2010 through 04/18/2010. Documentation received accounted for 22 units. 		

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;
- (c) Service documentation and billing activities; or
- (d) Time the individual spends in segregated facility-based settings activities.

- The Agency billed 35 units of Community Access from 04/19/2010 through 04/25/2010. Documentation received accounted for 22 units.

Tag # 5144 AH Reimbursement	Scope and Severity Rating: C		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 XVI. REIMBURSEMENT</p> <p>A. Billable Unit. A billable unit for Adult Habilitation</p>	<p>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 7 individuals.</p> <p>Individual #1 February 2010</p> <ul style="list-style-type: none"> • The Agency billed 120 units of Adult Habilitation from 02/01/2010 through 02/07/2010. No documentation found or provided by agency to justify billing. • The Agency billed 120 units of Adult Habilitation from 02/07/2010 through 02/14/2010. No documentation found or provided by agency to justify billing. • The Agency billed 120 units of Adult Habilitation from 02/15/2010 through 02/21/2010. No documentation found or provided by agency to justify billing. • The Agency billed 120 units of Adult Habilitation from 02/22/2010 through 02/28/2010. No documentation found or provided by agency to justify billing. <p>March 2010</p> <ul style="list-style-type: none"> • The Agency billed 120 units of Adult Habilitation from 03/01/2010 through 03/07/2010. No documentation found or provided by agency to justify billing. • The Agency billed 120 units of Adult Habilitation from 03/08/2010 through 03/14/2010. No documentation found or provided by agency to justify billing. • The Agency billed 120 units of Adult Habilitation from 03/15/2010 through 03/21/2010. No documentation found or provided by agency to 		

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

justify billing.

Individual #2

March 2010

- The Agency billed 116 units of Adult Habilitation from 03/01/2010 through 03/07/2010. Documentation received accounted for 96 units.

April 2010

- The Agency billed 102 units of Adult Habilitation from 04/19/2010 through 04/25/2010. Documentation did not contain start and end time on 04/23/2010 to justify billing.
- Documentation provided accounted for 88 units of Adult Habilitation on 04/26/2010 through 04/30/2010. Billing units were unable to be verified, remittance forms were not provided.

Individual #3

March 2010

- The Agency billed 120 units of Adult Habilitation from 03/08/2010 through 03/14/2010. Documentation received accounted for 108 units.
- The Agency billed 120 units of Adult Habilitation from 03/22/2010 through 03/28/2010. Documentation received accounted for 96 units.

April 2010

- Documentation provided accounted for 119 units of Adult Habilitation on 04/12/2010 through 04/18/2010. Billing units were unable to be verified, remittance forms were not provided.
- Documentation provided accounted for 102 units of Adult Habilitation on 04/26/2010 through 04/30/2010. Billing units were unable to be verified, remittance forms were not provided.

	<p>Individual #6 April 2010</p> <ul style="list-style-type: none"> • The Agency billed 113 units of Adult Habilitation from 04/12/2010 through 04/25/2010. Documentation received accounted for 112 units. <p>Individual #7 April 2010</p> <ul style="list-style-type: none"> • The Agency billed 24 units of Adult Habilitation from 03/29/2010 through 04/04/2010. No documentation found or provided by agency to justify billing. • The Agency billed 24 units of Adult Habilitation from 04/12/2010 through 04/18/2010. No documentation found or provided by agency to justify billing. • The Agency billed 24 units of Adult Habilitation from 04/19/2010 through 04/25/2010. No documentation found or provided by agency to justify billing. <p>Individual #8 April 2010</p> <ul style="list-style-type: none"> • Documentation provided accounted for 120 units of Adult Habilitation on 04/12/2010 through 04/18/2010. Billing units were unable to be verified, Individual was not included on remittance forms provided. • Documentation provided accounted for 72 units of Adult Habilitation on 04/26/2010 through 04/30/2010. Billing units were unable to be verified, remittance forms were not provided. <p>Individual #10 February 2010</p> <ul style="list-style-type: none"> • The Agency billed 120 units of Adult Habilitation from 02/01/2010 through 02/07/2010. 		
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	<p>Documentation received accounted for 48 units.</p> <ul style="list-style-type: none"> • The Agency billed 120 units of Adult Habilitation from 02/08/2010 through 02/14/2010. Documentation received accounted for 72 units. • The Agency billed 120 units of Adult Habilitation from 02/15/2010 through 02/21/2010. Documentation received accounted for 64 units. • The Agency billed 120 units of Adult Habilitation from 02/22/2010 through 02/28/2010. Documentation received accounted for 68 units. <p>March 2010</p> <ul style="list-style-type: none"> • The Agency billed 120 units of Adult Habilitation from 03/01/2010 through 03/07/2010. Documentation received accounted for 72 units. • The Agency billed 120 units of Adult Habilitation from 03/08/2010 through 03/14/2010. Documentation received accounted for 72 units. • The Agency billed 120 units of Adult Habilitation from 03/15/2010 through 03/21/2010. Documentation received accounted for 68 units. • The Agency billed 120 units of Adult Habilitation from 03/22/2010 through 03/28/2010. Documentation received accounted for 56 units. <p>April 2010</p> <ul style="list-style-type: none"> • The Agency billed 120 units of Adult Habilitation from 03/29/2010 through 04/04/2010. Documentation received accounted for 32 units. • The Agency billed 120 units of Adult Habilitation from 04/05/2010 through 04/11/2010. Documentation received accounted for 72 units. • The Agency billed 120 units of Adult Habilitation from 04/12/2010 through 04/18/2010. 		
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	<p>Documentation received accounted for 67 units.</p> <ul style="list-style-type: none">• The Agency billed 120 units of Adult Habilitation from 04/19/2010 through 04/25/2010. Documentation received accounted for 105 units.• Documentation provided accounted for 65 units of Adult Habilitation on 04/26/2010 through 04/30/2010. Billing units were unable to be verified, remittance forms were not provided.		
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Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</p> <p>G. Health Care Requirements for Community Living Services.</p> <p>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first.</p> <p>(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.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <p>(a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>b) That each individual with a score of 4, 5, or 6</p>	<p>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 2 of 12 individuals receiving Community Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Annual Physical (#7) • Vision Exam <ul style="list-style-type: none"> ◦ Individual #8 - As indicated by the documentation reviewed, exam was completed 03/2009. Follow-up was to be completed in 1 year. No evidence of follow-up found. 		

<p>on the HAT, has a Health Care Plan developed by a licensed nurse.</p> <p>(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.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <p>(a) The individual has a primary licensed physician;</p> <p>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</p> <p>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</p> <p>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</p> <p>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</p>			
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Tag # 6L14 Residential Case File	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>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:</p> <p>(1) Complete and current ISP and all supplemental plans specific to the individual;</p> <p>(2) Complete and current Health Assessment Tool;</p> <p>(3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;</p> <p>(4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);</p> <p>(5) Data collected to document ISP Action Plan implementation</p> <p>(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of a physician's or qualified health care provider's</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 9 of 12 Individuals receiving Family Living Services or Supported Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Positive Behavioral Plan (#2 & 3) • Positive Behavioral Crisis Plan (#2) • Speech Therapy Plan (#2, 5 & 10) • Special Health Care Needs <ul style="list-style-type: none"> ◦ Nutritional Plan (#1, 8 & 12) • Crisis Plan <ul style="list-style-type: none"> ◦ Allergies (#4) ◦ Gastrointestinal (#4) ◦ Aspiration (#10) • Data Collection/Data Tracking: <ul style="list-style-type: none"> ◦ Individual #1 - None found for June 1 - 7, 2010 ◦ Individual #8 - None found for June 1 - 9, 2010 • Progress Notes written by DSP and/or Nurses regarding Health Status: <ul style="list-style-type: none"> ◦ Individual #10 - None found for June 1 - 8, 2010 ◦ Individual #11 - None found for June 1 - 8, 2010 	

<p>order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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. <p>(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and</p> <p>(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 ...</p>			
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Tag # 6L17 Reporting Requirements (CL Quarterly Report Components)	Scope and Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>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:</p> <ul style="list-style-type: none"> (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. 	<p>Based on record review, the Agency failed to complete written quarterly status reports in compliance with standards for 1 of 12 individuals receiving Community Living Services.</p> <p>Review of quarterly reports found the following components were not addressed as required:</p> <p>Individual #8 - The following were not found in the Family Living Quarterly Report for 04/2009 - 03/2010:</p> <ul style="list-style-type: none"> (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (6) Data reports as determined by IDT members. 		

Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>L. Residence Requirements for Family Living Services and Supported Living Services</p> <p>(1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has:</p> <ul style="list-style-type: none"> (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence; (b) General-purpose first aid kit; (c) When applicable due to an individual's health status, a blood borne pathogens kit; (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats; (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone; (f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift; (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. 	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 4 of 11 Supported Living & Family Living residences.</p> <p>The following items were not found, not functioning or incomplete:</p> <p>Supported Living Requirements:</p> <ul style="list-style-type: none"> • 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 & 2) <p>Family Living Requirements:</p> <ul style="list-style-type: none"> • General-purpose first aid kit (#8) • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#8) • Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#11) 		

Tag # 6L25 (CoP) Residential Reqts. (Physical Environment - Supported Living & Family Living)	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>L. Residence Requirements for Family Living Services and Supported Living Services</p> <p>(2) Overall each residence shall maintain basic utilities, i.e., gas, power, water, telephone at the residence and shall maintain the physical environment in a safe and comfortable manner for the individuals.</p> <p>(3) Each individual shall have access to all household equipment and cleaning supplies unless precluded by his or her ISP.</p> <p>(4) Living and Dining Areas shall</p> <ul style="list-style-type: none"> (a) Provide individuals free use of all space with due regard for privacy, personal possessions and individual interests; (b) Maintain areas for the usual functions of daily living, social, and leisure activities in a clean and sanitary condition; and (c) Provide environmental accommodations based on the unique needs of the individual. <p>(5) Kitchen area shall:</p> <ul style="list-style-type: none"> (a) Possess equipment, utensils, and supplies to properly store, prepare, and serve at least three (3) meals a day; (b) Arrangements will be made, in consultation with the IDT for environmental accommodations and assistive technology devices specific to the needs of the individual(s); and (c) Water temperature is required to be maintained at a safe level to both prevent 	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard, which maintains a physical environment which is safe and comfortable for 1 of 11 Supported Living & Family Living residences.</p> <p>Family Living Requirements:</p> <p>During on-site visit (06/09/10), surveyors observed the following:</p> <p>Individual #8 had no door to his bedroom. Only a blanket was covering the entrance where a door should have been. When asked, DSP #50 stated that there was no door when they moved in (about one month prior) and they were in the process of getting a new door.</p>		

<p>injury and ensure comfort.</p> <p>(6) Bedroom area shall:</p> <ul style="list-style-type: none"> (a) At a maximum of two (2) individuals share, with mutual consent, a bedroom and each individual has the right to have his or her own bed; (b) All bedrooms shall have doors, which may be closed for privacy (c) Physical arrangement of bedrooms compatible with the physical needs of the individual; and (d) Allow individuals the right to decorate his or her bedroom in a style of his or her choice consistent with a safe and sanitary living conditions. <p>(7) Bathroom area shall provide:</p> <ul style="list-style-type: none"> (a) For Supported Living, a minimum of one toilet and lavatory facility for every two (2) individuals with Developmental Disabilities living in the home; (b) Reasonable modifications or accommodations, based on the physical needs of the individual (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.): <ul style="list-style-type: none"> (i) Toilets, tubs, showers used by the individual(s) provide for privacy; designed or adapted for the safe provision of personal care; and (ii) Water temperature maintained at a safe level to prevent injury and ensure comfort. 			
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Tag # 6L26 SL Reimbursement	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</p> <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 2 of 7 individuals.</p> <p>Individual #3 March 2010</p> <ul style="list-style-type: none"> • Documentation provided accounted for 7 units of Supporting Living Services from 03/18/2010 through 03/24/2010. Billing units were unable to be verified, Individual was not included on remittance forms provided. <p>April 2010</p> <ul style="list-style-type: none"> • Documentation provided accounted for 11 units of Supporting Living Services from 04/08/2010 through 04/18/2010. Billing units were unable to be verified, Individual was not included on remittance forms provided. • Documentation provided accounted for 5 units of Supporting Living Services from 04/26/2010 through 04/30/2010. Billing units were unable to be verified, Individual was not included on remittance forms provided. <p>Individual #5</p> <ul style="list-style-type: none"> • Documentation provided accounted for 25 units of Supporting Living Services from 04/06/2010 through 04/30/2010. Billing units were unable to be verified, Individual was not included on remittance forms provided. 		

A. Reimbursement for Supported Living Services

- (1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year.
- (2) **Billable Activities**
 - (a) Direct care provided to an individual in the residence any portion of the day.
 - (b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community.
 - (c) Any activities in which direct support staff provides in accordance with the Scope of Services.
- (3) Non-Billable Activities
 - (a) The Supported Living Services provider shall not bill DD Waiver for Room and Board.
 - (b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services.
 - (c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.

Tag # 6L27 FL Reimbursement	Scope and Severity Rating: B	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</p> <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 4 of 5 individuals.</p> <p>Individual #6 February 2010</p> <ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 01/28/2010 through 02/03/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 02/04/2010 through 02/10/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 02/11/2010 through 02/17/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 02/18/2010 through 02/24/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 02/25/2010 through 03/03/2010. Documentation did not contain start and end times to justify billing. <p>March 2010</p> <ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 03/04/2010 through 03/10/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 03/11/2010 through 03/17/2010. Documentation did not contain start and end 	

<p>B. Reimbursement for Family Living Services</p> <p>(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.</p> <p>(2) Billable Activities shall include:</p> <p>(a) Direct support provided to an individual in the residence any portion of the day;</p> <p>(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</p> <p>(c) Any other activities provided in accordance with the Scope of Services.</p> <p>(3) Non-Billable Activities shall include:</p> <p>(a) The Family Living Services Provider Agency may not bill the for room and board;</p> <p>(b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and</p> <p>(c) Family Living services may not be billed for the same time period as Respite.</p> <p>(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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - Chapter 6 - COMMUNITY LIVING SERVICES</p> <p>III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES</p> <p>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,</p>	<p>times to justify billing.</p> <ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 03/18/2010 through 03/24/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 03/25/2010 through 03/31/2010. Documentation did not contain start and end times to justify billing. <p>April 2010</p> <ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 04/01/2010 through 04/07/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 04/08/2010 through 04/14/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 04/15/2010 through 04/21/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 04/22/2010 through 04/28/2010. Documentation did not contain start and end times to justify billing. <p>Individual #7 February 2010</p> <ul style="list-style-type: none"> • The Agency billed 7 units of Family Living from 02/04/2010 through 02/10/2010. No documentation found or provided by agency to justify billing. • The Agency billed 7 units of Supported Living from 02/11/2010 through 02/47/2010. No 	
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<p>a specified deduction to the daily rate for Family Living shall be made for each unit of respite received.</p> <p>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.</p> <p>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.</p>	<p>documentation found or provided by agency to justify billing.</p> <ul style="list-style-type: none"> • The Agency billed a total of 7 units of Family Living Services on 02/18//2010 through 02/24/2010 documentation did not contain a description of what occurred during the encounter or service interval to justify billing. • The Agency billed a total of 7 units of Family Living Services on 02/25/2010 through 03/03/2010 documentation did not contain a description of what occurred during the encounter or service interval on 02/25, 26, 27 & 28, 2010 to justify billing. • The Agency billed 7 units of Family Living Services from 02/18/2010 through 02/24/2010. Documentation did not contain start and end time to justify billing. • The Agency billed 7 units of Family Living Services from 02/25/2010 through 03/03/2010. Documentation did not contain start and end time to justify billing. • The Agency billed 11 units of Family Living Services from 02/18/2010 through 02/28/2010. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes. <p>March 2010</p> <ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 03/04/2010 through 03/10/2010. Documentation did not contain start and end time to justify billing. • The Agency billed 7 units of Family Living Services from 03/11/2010 through 03/17/2010. 	
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	<p>Documentation did not contain start and end time to justify billing.</p> <ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 03/18/2010 through 03/24/2010. Documentation did not contain start and end time to justify billing. • The Agency billed 7 units of Family Living Services from 03/25/2010 through 03/31/2010. Documentation did not contain start and end time to justify billing. <p>April 2010</p> <ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 04/01/2010 through 04/07/2010. Documentation did not contain start and end time to justify billing. • The Agency billed 7 units of Family Living Services from 04/08/2010 through 04/14/2010. Documentation did not contain start and end time to justify billing. • Documentation provided accounted for 7 units of Family Living Services on 04/15/2010 through 04/21/2010. Billing units were unable to be verified, Individual was not included on remittance forms provided. • The Agency billed 7 units of Family Living Services from 04/22/2010 through 04/28/2010. Documentation did not contain start and end time to justify billing. <p>Individual #8 February 2010</p> <ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 01/28/2010 through 02/03/2010. Documentation did not contain start and end times to justify billing. 		
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	<ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 02/04/2010 through 02/10/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 02/11/2010 through 02/17/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 02/18/2010 through 02/24/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 02/25/2010 through 03/03/2010. Documentation did not contain start and end times to justify billing. <p>March 2010</p> <ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 03/04/2010 through 03/10/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 03/11/2010 through 03/17/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 03/18/2010 through 03/24/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 03/25/2010 through 03/31/2010. Documentation did not contain start and end times to justify billing. <p>April 2010</p>		
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	<ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 04/01/2010 through 04/07/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 04/08/2010 through 04/14/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 04/15/2010 through 04/21/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 04/22/2010 through 04/28/2010. Documentation did not contain start and end times to justify billing. <p>Individual #12 February 2010</p> <ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 01/28/2010 through 02/03/2010. Documentation did not contain start and end time on 02/01 & 02/02 to justify billing. • The Agency billed 7 units of Family Living Services from 02/04/2010 through 02/10/2010. Documentation did not contain start and end time on 02/05, 02/07, 02/08, 02/09 & 02/10 to justify billing. • The Agency billed 7 units of Family Living Services from 02/11/2010 through 02/17/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 02/18/2010 through 02/24/2010. Documentation did not contain start and end times to justify billing. 		
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	<ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 02/25/2010 through 03/03/2010. Documentation did not contain start and end times to justify billing. <p>March 2010</p> <ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 03/04/2010 through 03/10/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 03/11/2010 through 03/17/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 03/18/2010 through 03/24/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 03/25/2010 through 03/31/2010. Documentation did not contain start and end times to justify billing. <p>April 2010</p> <ul style="list-style-type: none"> • The Agency billed 7 units of Family Living Services from 04/01/2010 through 04/07/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 04/08/2010 through 04/14/2010. Documentation did not contain start and end times to justify billing. • The Agency billed 7 units of Family Living Services from 04/15/2010 through 04/21/2010. Documentation did not contain start and end times to justify billing. 		
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	<ul style="list-style-type: none">• The Agency billed 7 units of Family Living Services from 04/22/2010 through 04/28/2010. Documentation did not contain start and end times to justify billing.		
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