

Date: January 6, 2011
To: Eddie Ruiz
Provider: Lessons of Life, LLC
Address: 2293 Divot Avenue
State/Zip: Las Cruces, NM 88001

E-mail Address: eruiz@zianet.com
romero@lessonsoflifellc.com

Region: Southwest
Survey Date: October 25 – 28, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living, Family Living & Independent Living) & Community Inclusion (Community Access & Supported Employment)
Survey Type: Routine
Team Leader: Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Cynthia Nielsen, RN, MSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Valerie V. Valdez, MS, Healthcare Program Manager/Surveyor, Division of Health Improvement/Quality Management Bureau; Stephanie Martinez de Berenger, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Zach Robinson, Social & Community Services Coordinator, Developmental Disabilities Supports Division

Dear Mr. Ruiz;

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

Quality Management Compliance Determination:

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

Plan of Correction:

The attached Report of Findings identifies deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. See attachment "A" for additional guidance in completing the Plan of Correction. 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**



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

Roger Gillespie, Acting 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>

QMB Report of Findings – Lessons of Life, LLC - Southwest Region – October 25 - 28, 2010

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 as soon as possible for approval, as all remedies must still be completed within 45 working days of the receipt of this letter.

Failure to submit, complete or implement your Plan of Correction within the 45 day required time frames may result in the imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Request for Informal Reconsideration of Findings (IRF):

If you disagree with a finding of deficient practice, you have 10 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

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 working days. Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator at 505-222-8647 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Deb Russell, BS

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

Survey Process Employed:

Entrance Conference Date: October 25, 2010

Present: **Lessons of Life, LLC**
Rey Romero, Member Manager

DOH/DHI/QMB
Deb Russell, BS, Team Lead/Healthcare Surveyor
Valerie V. Valdez, MS, Healthcare Program Manager/Healthcare Surveyor
Cynthia Nielsen, RN, MSN, Healthcare Surveyor

Exit Conference Date: October 28, 2010

Present: **Lessons of Life, LLC**
Rey Romero, Member Manager
Julie Russell, Service Coordinator
Chris Montoya, Manager
Jessica D. Chavez, Human Resources Manager
Manny Renteria, Service Coordinator

DOH/DHI/QMB
Deb Russell, BS, Team Lead/Healthcare Surveyor
Cynthia Nielsen, RN, MSN, Healthcare Surveyor

DDSD - Southwest Regional Office
Zack Robinson, Social & Community Services Coordinator

Total Homes Visited	Number:	12
❖ Supported Homes Visited	Number:	4
❖ Family Homes Visited	Number:	8
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	16 3 - <i>Jackson Class Members</i> 13 - <i>Non-Jackson Class Members</i> 4 - Supported Living 9 - Family Living 3 - Independent Living 13 - Community Access 4 - Supported Employment
Persons Served Interviewed	Number:	10
Persons Served Observed	Number:	6 (These 6 Individuals did not respond to Surveyors' questions)
Direct Service Professionals Interviewed	Number:	15
Records Reviewed (Persons Served)	Number:	16
Administrative Files Reviewed		<ul style="list-style-type: none">• Billing Records• Medical Records• Incident Management Records• Personnel Files

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

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

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

Introduction:

After a QMB Compliance Review, your QMB Report of Findings will be sent to you via US mail.

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

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

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-222-8647 or email at George.Perrault@state.nm.us. Requests for technical assistance must be requested through your DDS Regional Office.

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

Instructions for Completing Agency POC:

Required Content

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan. (see page 3, DDW standards, effective; April 1, 2007, Chapter 1, Section I Continuous Quality Management System)

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

The Plan of Correction you submit needs to address **each deficiency** in the two right hand columns with:

1. How the corrective action will be accomplished for all cited deficiencies in the report of findings;
2. How your Agency will identify all other individuals having the potential to be affected by the same deficient practice;
3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur and corrective action is sustained;
4. How your Agency plans to monitor corrective actions utilizing its continuous Quality Assurance/Quality Improvement Plan to assure solutions in the plan of correction are achieved and sustained, including (if appropriate):
 - Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
 - Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
 - Your processes for ensuring that all staff are trained in Core Competencies, Incident Reporting, and Individual-Specific service requirements, etc;
 - How accuracy in Billing documentation is assured;

- How health, safety is assured;
 - For Case Management Providers, how ISPs are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
 - Your process for gathering, analyzing and responding to Quality data, and
 - Details about Quality Targets in various areas, current status, Analyses about why Targets were not met, and remedies implemented.
5. The individual's title responsible for the Plan of Correction and completion date.

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

Completion Dates

The plan of correction must include a **completion date** (entered in the far right-hand column). Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 days.

Direct care issues should be corrected immediately and monitored appropriately. Some deficiencies may require a staged plan to accomplish total correction. Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

Plan of Correction Submission Requirements

1. Your Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. If you have questions about the POC process, call the POC Coordinator, George Perrault at 505-222-8647 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to George Perrault, POC Coordinator in any of the following ways:
 - a. Electronically at George.Perrault@state.nm.us
 - b. Faxed to 505-222-8661, or
 - c. Mailed to QMB, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not send supporting documentation to QMB until after your POC has been approved by QMB.
6. QMB will notify you when your POC has been "approve" or "denied."
 - a. Whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
 - b. If your POC is "Denied" it must be revised and resubmitted as soon as possible, as the 45 working day limit is in effect.
 - c. If your POC is "Denied" a second time your agency may be referred to the Internal Review Committee.
 - d. You will receive written confirmation that your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.
8. Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

POC Document Submission Requirements

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

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

QMB Scope and Severity Matrix

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 Compliance Determination.

		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:

- **Isolated:**
A deficiency that is limited to 1% to 15% of the sample, usually impacting few 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 could be referred to the Internal Review Committee for review and possible actions or sanctions.

QMB Determinations of Compliance

- “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 be in compliance with all Conditions 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 QMB Survey 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. Providers may use the following process to informally dispute a finding.

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be in writing to the QMB Deputy Bureau Chief **within 10 working days** of receipt of the final report.
2. The written request for an IRF must be completed on the QMB Request for Informal Reconsideration of Finding Form available on the QMB website: <http://dhi.health.state.nm.us/qmb>
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received within 10 working days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed or requested by the survey team.
- Providers must continue to complete their Plan of Correction during the IRF process
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition.
- Providers may not request an IRF to challenge the QMB compliance determination or the length of their DDS 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/or 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 removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.

Agency: Lessons of Life, LLC - Southwest Region
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living, Family Living & Independent Living) & Community Inclusion (Community Access & Supported Employment)
Monitoring Type: Routine Survey
Date of Survey: October 25 – 28, 2010

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
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> <p>(a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand</p>	<p>Medication Administration Records (MAR) were reviewed for the months of July, August & September 2010.</p> <p>Based on record review, 8 of 16 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #3 September 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Os-Cal 500mg (3 times daily) – Blank 9/30 (12:00 PM & 9:00 PM) • Colace 100mg (2 times daily) – Blank 9/30 (9:00 PM) • Phenytoin Extended (3 times daily) – Blank 9/30 (2:00 PM & 9:00 PM) • Phenobarbital (2 times daily) – Blank 9/30 (2:00 PM) <p>Individual #6 July 2010 Medication Administration Records did not contain the frequency of medication to be given:</p>		

<p>and generic name of the medication, diagnosis for which the medication is prescribed;</p> <p>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</p> <p>(c) Initials of the individual administering or assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</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"> • Ibuprofen 600mg <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Ibuprofen 600mg <p>Individual #7 August 2010 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxine 150mg (1 time daily) • Multivitamin (1 time daily) <p>September 2010 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxine 150mg (1 time daily) • Multivitamin (1 time daily) <p>Individual #8 September 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Prevalite Powder <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Prevalite Powder <p>Medication Administration Records did not contain the route of administration for the following medications:</p>		
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<p>(i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications.</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"> • Prevalite Powder <p>Individual #13 September 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Pheregan with Codiene 10ml (4 times daily) – Blank 9/15 (8:00 PM) <p>Individual #14 July 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Seroquel 300mg (1 time daily) – Blank 7/20 (8:00 PM) • Calcium Plus D (2 times daily) – Blank 7/20 (8:00 PM) • Sinemet 25/250 (3 times daily) – Blank 7/20 (8:00 PM) • Venafaxine/Effexor 75mg (2 times daily) – Blank 7/20 & 25 (8:00 PM) <p>Individual #15 July 2010 As indicated by the Medication Administration Records the individual is to take Lisinopril 5mg (1 time every other day). Medication Administration Records document:</p> <ul style="list-style-type: none"> • Lisinopril 5mg (1 time every other day) – Initialed as given on 7/10, 11,12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (8:00 AM & 8:00 PM) <p>Individual #16 August 2010 Medication Administration Records contained missing entries. No documentation found</p>		
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	<p>indicating reason for missing entries:</p> <ul style="list-style-type: none">• Imodium (1 time daily) – Blank 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (9:00 AM)• Benefiber (1 time daily) – Blank 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (9:00 AM)		
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Tag # 1A09.1 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> <ul style="list-style-type: none"> (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and 	<p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 7 of 16 Individuals.</p> <p>Individual #3 September 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Hydrochlorothiazide (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Hydrochlorothiazide (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Hydrochlorothiazide – PRN – 9/22, 23, 24 & 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"> • Hydrochlorothiazide – PRN – 9/22, 23, 24 & 25 (given 1 time) <p>No Time of Administration was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Hydrochlorothiazide – PRN – 9/22, 23, 24 & 25 (given 1 time) <p>Individual #5 July 2010 Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include</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>required information as per standard:</p> <ul style="list-style-type: none"> • Tylenol <p>Individual #6 July 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Claritin 10mg (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Claritin 10mg – PRN – 7/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (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"> • Claritin 10mg – PRN – 7/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 time) <p>No Time of Administration was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Claritin 10mg – PRN – 7/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 time) <p>August 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Claritin 10mg (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the</p>	
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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>following PRN medication:</p> <ul style="list-style-type: none"> • Claritin 10mg – PRN – 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (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"> • Claritin 10mg – PRN – 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 time) <p>No Time of Administration was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Claritin 10mg – PRN – 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 time) <p>September 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Claritin 10mg (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Claritin 10mg – PRN – 9/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (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"> • Claritin 10mg – PRN – 9/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 1 		
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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.

time)

No Time of Administration was noted on the Medication Administration Record for the following PRN medication:

- Claritin 10mg – PRN – 9/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 1 time)

Individual #9

September 2010

Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard:

- Midol

Individual #10

August 2010

No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:

- Chronulac Syrup – PRN – 8/8 (given 1 time)
- Tylenol 500mg – PRN – 9/7 (given 1 time)

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:

- Chronulac Syrup – PRN – 8/8 (given 1 time)
- Tylenol 500mg – PRN – 9/7 (given 1 time)

Individual #13

August 2010

No Time of Administration was noted on the Medication Administration Record for the following PRN medication:

- Ibuprofen 400mg – PRN – 8/15 (given 1 time)

September 2010

<p>(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).</p> <p>a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.</p> <p>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.).</p>	<p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> •Ibuprofen 400mg – PRN – Month 9/16 (given 1 time) <p>No Time of Administration was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> •Ibuprofen 400mg – PRN – 9/16 (given 1 time) •Lactulose 10g/15ml – PRN – 9/14 & 15 (given 1 time) <p>Individual #14 August 2010</p> <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"> •Milk of Magnesia (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> •Milk of Magnesia (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> •Milk of Magnesia – PRN – 8/4, 13 & 21 (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"> •Milk of Magnesia – PRN – 8/4, 13 & 21 (given 1 time) <p>No Time of Administration was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> •Milk of Magnesia – PRN – 8/4, 13 & 21 (given 1 		
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	<p>time)</p> <p>Individual #16 July 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Excedrin 250mg (PRN)</p> <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Excedrin 250mg – PRN – 7/4, 5, 7, 18, 20, 21, 24 & 27 (given 1 time); 7/25, 26, 28 & 29 (given 2 times)</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Excedrin 250mg – PRN – 7/4, 5, 7, 18, 20, 21, 24 & 27 (given 1 time); 7/25, 26, 28 & 29 (given 2 times)</p> <p>August 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Excedrin 250mg (PRN)</p> <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Excedrin 250mg – PRN – 8/1, 3, 4, 5, 6, 7, 9, 10, 13, 15, 23, 25, 29 & 30 (given 1 time); 8/8, & 8/18 (given 2 times); 8/27 (given 3 times); 8/22 (given 4 times)</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Excedrin 250mg – PRN – 8/1, 3, 4, 5, 6, 7, 9,</p>		
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	<p>10, 13, 15, 23, 25, 29 & 30 (given 1 time); 8/8, & 8/18 (given 2 times); 8/27 (given 3 times); 8/22 (given 4 times)</p> <p>September 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Excedrin 250mg (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Excedrin 250mg – PRN – 9/2, 7, 10, 11, 12, 16, 17, 18, 20, 23, 26, 27, 28, 29 & 30 (given 1 time); 9/19 & 24 (given 2 times); 9/9 (given 3 times) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Excedrin 250mg – PRN – 9/2, 7, 10, 11, 12, 16, 17, 18, 20, 23, 26, 27, 28, 29 & 30 (given 1 time); 9/19 & 24 (given 2 times); 9/9 (given 3 times) 		
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Tag # 1A11.1 (CoP) Transportation Training	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>G. Transportation: Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety". The policy and procedures must address at least the following topics:</p> <ol style="list-style-type: none"> (1) Drivers' requirements, (2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions, (3) Vehicle maintenance and safety inspections, (4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures, (5) Emergency Plans, including vehicle evacuation techniques, (6) Documentation, and (7) Accident Procedures. <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff Date: March 1, 2007</p>	<p>Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 63 of 134 Direct Service Professionals.</p> <p>No documented evidence was found of the following required training:</p> <ul style="list-style-type: none"> • Transportation (DSP #40, 44, 48, 49, 52, 55, 58, 62, 63, 64, 68, 70, 71, 72, 75, 76, 77, 78, 82, 83, 87, 88, 89, 91, 92, 94, 96, 98, 99, 102, 103, 105, 106, 109, 111, 116, 119, 121, 122, 125, 126, 128, 131, 135, 141, 145, 148, 151, 153, 154, 156, 158, 159, 161, 162, 164, 165, 166, 167, 168, 171, 172 & 173) <p>When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported:</p> <p>DSP #55 stated, "Not yet."</p> <p>DSP #58 stated, "No."</p>		

II. POLICY STATEMENTS:

1. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:

1. Operating a fire extinguisher
2. Proper lifting procedures
3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat)
4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)
5. Operating wheelchair lifts (if applicable to the staff's role)
6. Wheelchair tie-down procedures (if applicable to the staff's role)
7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)

Tag # 1A15.2 & 5109 - Healthcare Documentation	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</p> <p>(a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training:</p> <ul style="list-style-type: none"> (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. <p>(b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 1 of 16 individual</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Health Care Plans <ul style="list-style-type: none"> • Health Care Plan <ul style="list-style-type: none"> ◦ Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. 		

<p>agency nurse must be available to assist the caregiver upon request.</p> <p>(c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first.</p> <p>(d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDS Medication Assessment and Delivery Policy).</p> <p>(e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as <i>subjective</i> information including the individual complaints, signs and symptoms noted by staff, family members or other team members; <i>objective</i> information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); <i>assessment</i> of the clinical status, and <i>plan</i> of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.</p> <p>(2) Health related plans</p> <p>(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare</p>			
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<p>professional.</p> <p>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.</p> <p>(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.</p> <p>(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.</p> <p>(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):</p> <p>(a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.</p> <p>(b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.</p> <p>(c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention</p>			
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<p>shall be specified in the plan.</p> <p>(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.</p> <p>(e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings.</p> <p>(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.</p> <p>(g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author.</p> <p>(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.</p> <p>(4) General Nursing Documentation</p> <p>(a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person.</p> <p>(b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p>			
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CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS

B. IDT Coordination

(1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and

(2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: F	
<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</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 111 of 134 Direct Service Professionals.</p> <p>Review of Direct Service Professional 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 #72, 81, 95 & 109) • Basic Health/Orientation (DSP #71, 72, 81 & 109) • Person-Centered Planning (1-Day) (DSP #67, 72, 73, 81, 84, 85, 95, 109, 151, 153, 154, 155, 156, 158, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169 & 173) • First Aid (DSP #41, 45, 49, 53, 55, 59, 62, 63, 65, 71, 72, 74, 77, 82, 83, 84, 88, 90, 91, 92, 93, 102, 119, 122, 125, 133, 134, 142, 143, 148, 160, 161, 162, 166 & 168) • CPR (DSP #42, 44, 45, 49, 59, 62, 63, 65, 72, 76, 77, 82, 84, 88, 91, 92, 93, 97, 100, 102, 105, 108, 115, 117, 118, 119, 122, 125, 133, 134, 136, 139, 141, 142, 148, 160, 161, 162 & 166) • Assisting With Medication Delivery (DSP #40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 53, 54, 55, 56, 57, 58, 60, 61, 63, 64, 65, 66, 67, 69, 70, 72, 74, 76, 78, 79, 81, 84, 85, 86, 87, 89, 90, 92, 94, 96, 97, 98, 99, 100, 102, 105, 106, 108, 109, 112, 113, 119, 120, 122, 123, 124, 125, 126, 127, 129, 130, 131, 133, 134, 136, 138, 139, 140, 141, 142, 143, 146, 147, 148, 149, 150, 152, 153, 154, 158, 160, 161, 162, 164, 166, 167, 168 & 173) • Rights & Advocacy (DSP #51, 73, 81, 84, 85, 112, 114, 126, 146, 153, 156, 163 & 169) 	

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

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

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

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

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

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

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

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

- Level 1 Health (DSP #73, 81, 84, 85, 112, 114, 126, 136, 146, 152, 153, 156, 163 & 169)
- Teaching & Support Strategies (DSP #73, 74, 79, 81, 84, 85, 112, 114, 126, 140, 146, 152, 153, 156, 163 & 169)
- Positive Behavior Supports Strategies (DSP #51, 73, 79, 81, 84, 85, 114, 146, 153, 156, 163 & 169)
- Participatory Communication & Choice Making (DSP #51, 73, 81, 84, 85, 114, 136, 146, 152, 153, 156, 163 & 169)

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: D		
<p>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p> <p>E. Documentation for other staff. With</p>	<p>Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 14 of 137 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #56 – Date of hire 6/30/2009. Completed 10/27/2010. • #62 – Date of hire 6/18/2010. Completed 10/27/2010. • #64 – Date of hire 11/19/2009. Completed 12/3/2009. • #87 – Date of hire 11/16/2009. Completed 6/25/2010. • #105 – Date of hire 3/19/2010. Completed 9/29/2010. • #106 – Date of hire 10/1/2010. Completed 10/24/2010. • #120 – Date of hire 8/16/2008. Completed 10/24/2008. • #127 – Date of hire 2/26/2010. Completed 3/9/2010. • #128 – Date of hire 10/1/2008. Completed 10/23/2008. • #131 – Date of hire 2/10/2010. Completed 2/22/2010. • #135 – Date of hire 6/14/2010. Completed 		

respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.

F. **Consequences of noncompliance.** The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007

Chapter 1.IV. General Provider Requirements.

D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

10/28/2010.

- #136 – Date of hire 7/1/2010. Completed 10/28/2010.
- #155 – Date of hire 3/26/2010. Completed 4/8/2010.
- #158 – Date of hire 2/10/2010. Completed 2/22/2010.

Tag # 1A27 (CoP) Late & Failure to Report	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: (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 1 of 16 individuals.</p> <p>Individual #13</p> <ul style="list-style-type: none"> Incident date 7/23/2010. Allegation was Neglect. Incident report was received 7/29/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." 		

Tag # 1A28.1 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: E		
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</p> <p>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p>	<p>Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 30 of 137 Agency Personnel.</p> <ul style="list-style-type: none"> Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#41, 48, 53, 64, 68, 72, 84, 85, 86, 88, 89, 75, 78, 100, 102, 105, 109, 127, 141, 148, 154, 157, 159, 163, 166,167, 169, 171, 172 & 176) 		

Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: D		
<p>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:</p> <p>A. A service provider shall not restrict or limit a client's rights except:</p> <p>(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or</p> <p>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or</p> <p>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].</p> <p>B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy.</p> <p>C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p>Long Term Services Division Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003 IV. POLICY STATEMENT - Human Rights Committees are required for residential service provider agencies. The purpose of these</p>	<p>Based on record review, the Agency failed to ensure the rights of Individuals was not restricted or limited for 1 of 16 Individuals.</p> <p>A review of Agency Individual files indicated 1 of 16 Individuals required Human Rights Committee Approval for restrictions.</p> <p>No documentation was found regarding current Human Rights Approval for the following:</p> <ul style="list-style-type: none"> • Physical Restriction (sharps, auto lock, response – cost, physical restraint & door alarms) - (Individual #4) • Psychotropic Medications to control behaviors. No evidence found of Human Rights Committee approval. (Individual #4) 		

committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:

- Aversive Intervention Prohibitions
- Psychotropic Medications Use
- Behavioral Support Service Provision.

A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up.

A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS

Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval.

2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly.

3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual's Individual Service Plan.

Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006

B. 1. e. If the PRN medication is to be used in

response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).

Tag # 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 1 of 16 individuals.</p> <p>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Independent Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes: Individual #15</p> <ul style="list-style-type: none"> • No Outcomes/Action Plans or DDSD exemption/decision justification found for Independent Living Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver." 		

Tag # 1A36 SC Training	Scope and Severity Rating: B		
<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 DDSD/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>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 2 of 3 Service Coordinators.</p> <p>Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:</p> <ul style="list-style-type: none"> • Pre-Service Manual (SC #174) • Person Centered Planning (2-Day) (SC #176) • Participatory Communication and Choice Making (SC #174) 		

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: D		
<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>(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 individual service plan (ISP) of each individual served.</p>	<p>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 16 of 137 Agency Personnel.</p> <p>Review of personnel records found no evidence of the following:</p> <ul style="list-style-type: none"> Individual Specific Training (#48, 68, 72, 75, 78, 96, 109, 148, 154, 159, 162, 164, 166, 167, 171 & 172) 		

Tag # 5I36 CA 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 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS</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 5 of 13 individuals.</p> <p>Individual #1 July 2010</p> <ul style="list-style-type: none"> • The Agency billed 204 units of Community Access from 7/1/2010 through 7/10/2010. Documentation did not contain start and end time on July 7 to justify billing. <p>September 2010</p> <ul style="list-style-type: none"> • The Agency billed 204 units of Community Access from 9/1/2010 through 9/10/2010. Documentation received accounted for 160 units. <p>Individual #2 August 2010</p> <ul style="list-style-type: none"> • The Agency billed 220 units of Community Access from 8/16/2010 through 8/31/2010. Documentation received accounted for 180 units. <p>Individual #3 August 2010</p> <ul style="list-style-type: none"> • The Agency billed 352 units of Community Access from 8/1/2010 through 8/31/2010. Documentation received accounted for 288 units. <p>Individual #4 July 2010</p> <ul style="list-style-type: none"> • The Agency billed 566 units of Community Access from 7/1/2010 through 7/31/2010. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained one signature for each set of progress notes. 	

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 566 units of Community Access from 7/1/2010 through 7/31/2010. Documentation received accounted for 350 units.

August 2010

- The Agency billed 354 units of Community Access from 8/1/2010 through 8/31/2010. 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.
- The Agency billed 566 units of Community Access from 7/1/2010 through 7/31/2010. Documentation received accounted for 350 units.

September 2010

- The Agency billed 272 units of Community Access from 9/1/2010 through 9/30/2010. 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.
- The Agency billed 272 units of Community Access from 7/1/2010 through 7/31/2010. Documentation received accounted for 230 units.

Individual #6

September 2010

- The Agency billed 176 units of Community Access from 9/1/2010 through 9/15/2010. Documentation received accounted for 160 units.

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 16 individuals receiving Community Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Vision Exam <ul style="list-style-type: none"> ◦ Individual #8 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #12 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. 		

<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</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 6 of 13 Individuals receiving Family Living Services or Supported Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <p>Supported Living Residential Case Files:</p> <ul style="list-style-type: none"> • Speech Therapy Plan (#4) • Physical Therapy Plan (#4) • Crisis Plan <ul style="list-style-type: none"> ◦ Respiratory (#14) ◦ Bleeding Precautions (#14) • Data Collection/Data Tracking: <ul style="list-style-type: none"> ◦ Individual #14 - None found for October 2010 <p>Family Living Residential Case Files:</p> <ul style="list-style-type: none"> • Annual ISP (#5) • Speech Therapy Plan (#2) • Special Health Care Needs <ul style="list-style-type: none"> ◦ Meal Time Plan (#2) • Data Collection/Data Tracking: <ul style="list-style-type: none"> ◦ Individual #6 - None found for October 2010 ◦ Individual #8 - None found for October 2010 • Health Care Providers Written Orders (#8) 		

<p>a physician's or qualified health care provider's 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...</p>			
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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 7 of 12 Supported Living & Family Living residences.</p> <p>Individuals #6 & 8 live in the same residence.</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 evacuation e.g. fire and weather-related threats (#14) • 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 (#14) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#4, 10 & 14) <p>Family Living Requirements:</p> <ul style="list-style-type: none"> • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#2) • 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 (#2, 6, 8, 9 & 16)		
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Tag # 6L27 FL Reimbursement	Scope and Severity Rating: A		
<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 1 of 9 individuals.</p> <p>Individual #3 July 2010</p> <ul style="list-style-type: none"> • The Agency billed 26 units of Family Living from 7/1/2010 through 7/28/2010. Documentation did not contain start and end time on 7/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 & 28 to justify billing. 		

- B. Reimbursement for Family Living Services
- (1) Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year.
- (2) Billable Activities shall include:
- (a) Direct support provided to an individual in the residence any portion of the day;
 - (b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and
 - (c) Any other activities provided in accordance with the Scope of Services.
- (3) Non-Billable Activities shall include:
- (a) The Family Living Services Provider Agency may not bill the for room and board;
 - (b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and
 - (c) Family Living services may not be billed for the same time period as Respite.
 - (d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one midnight to the following midnight.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **Chapter 6 - COMMUNITY LIVING SERVICES**
III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES

C. Service Limitations. Family Living Services cannot be provided in conjunction with any other Community Living Service, Personal Support Service, Private Duty Nursing, or Nutritional Counseling. In addition, Family Living may not be delivered during the same time as respite; therefore,

a specified deduction to the daily rate for Family Living shall be made for each unit of respite received.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **DEFINITIONS**
SUBSTITUTE CARE means the provision of family living services by an agency staff or subcontractor during a planned/scheduled or emergency absence of the direct service provider.

RESPITE means a support service to allow the primary caregiver to take a break from care giving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.