Date: July 21, 2010

To: Evangeline H. Zamora, Chief Executive Officer

Provider: Life Quest
Address: 907 Pope Street
State/Zip: Silver City, New Mexico 88061

E-mail Address: ezamora@lifequestnm.org

CC: Alfred Sedillo, Board Chair
Address: PO Box 2182
State/Zip: Silver City, New Mexico 88061

Board chair
E-Mail Address: asedillo@grantcountynm.com

Region: Southwest
Original Survey Date: February 8 - 10, 2010
Verification Survey Date: July 13 - 14, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living, Family Living & Independent Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Survey Type: Verification
Team Leader: Valerie V. Valdez, MS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Zamora,

The Division of Health Improvement/Quality Management Bureau has completed a verification survey of the services identified above. The purpose of the survey was to determine compliance with you Plan of Correction submitted to DHI/DDSD regarding the Routine Survey on **February 8 – 10, 2010.**

These findings will be reviewed by the DOH – Internal Review Committee during an upcoming review meeting. You will be contacted by the Department for further instructions regarding your plan of correction requirements.

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

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

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

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

Please call the Team Leader at 575-528-5037 or 575-649-7912, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

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

Survey Process Employed:

Entrance Conference Date:	July 13, 2010
Present:	**Life Quest** Deb Norquist, Adult Services/Business Office Director Joseph A. Jensen III, Human Resources/Staff Development Director **DOH/DHI/QMB** Valerie V. Valdez, MS, Team Lead/Healthcare Program Manager/ Healthcare Surveyor
Exit Conference Date:	July 13, 2010
Present:	**Life Quest** Deb Norquist, Adult Services/Business Office Director Joseph A. Jensen III, Human Resources/Staff Development Director **DOH/DHI/QMB** Valerie V. Valdez,, MS, Team Lead/Healthcare Program Manager/ Healthcare Surveyor
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 11 1 - Jackson Class Members 10 - Non-Jackson Class Members 5 - Supported Living 4 - Family Living 2 - Independent Living 10 - Adult Habilitation 5 - Community Access 8 - Supported Employment
Records Reviewed (Persons Served)	Number: 11
Administrative Files Reviewed	• Billing Records • Medical Records • Incident Management Records • Personnel Files • Training Records • Agency Policy and Procedure • Caregiver Criminal History Screening Records • Employee Abuse Registry • Human Rights Notes and/or Meeting Minutes • Nursing personnel files • Evacuation Drills • Quality Improvement/Quality Assurance Plan

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

Attachment B

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

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

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

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

Key to Findings:

"Substantial Compliance with Conditions of Participation"
The QMB determination of "Substantial Compliance with Conditions of Participation" indicates that a provider is in substantial compliance with all 'Conditions of Participation' and other standards and regulations. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Substantial Compliance with Conditions of Participation, the provider must not have any findings that meet the thresholds for determining non-compliance with any Condition of Participation.

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

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

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

Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm. Any finding of actual harm or Immediate Jeopardy.

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

Attachment C

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

Introduction:

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

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

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

The following limitations apply to the IRF process:

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

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

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

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

Agency: **Life Quest - Southwest Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living, Family Living & Independent Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Verification Survey
Date of Original Survey: **February 8 - 10, 2010**
Date of Verification Survey: **July 13 – 14, 2010**

Statute	February 8 – 10, 2010 Routine Survey Deficiencies	July 13 – 14, 2010 Verification Survey - New and Repeat Deficiencies
Tag # 1A03 CQI System	**Scope and Severity Rating: C**	**Scope and Severity Rating: N/A**
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS** **I. Continuous Quality Management System:** Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans;	Based on record review, the Agency failed to implement a Continuous Quality Management System. Review of the Agency's Continuous Quality Improvement Plan provided during the on-site survey did not contain evidence of the following components being completed as required by Standards: (2) Effectiveness and timeliness of implementation of Individualized Service Plans. No evidence found of how the Agency is ensuring the effectiveness and timeliness of ISP implementation. (3) Trends in achievement of individual outcomes in the Individual Service Plans. No evidence found of trends being completed. (4) Trends in medication and medical incidents leading to adverse health events. No evidence found of trends being completed. (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels. No evidence found of trends being completed. Based on record review, the Agency failed to	Complete

(4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction. **7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:** **E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system: **(1)** community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements; **(2)** community based service providers providing developmental disabilities services must have a designated incident management coordinator in place; **(4)** community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.	establish and implement a quality improvement system for reviewing alleged complaints and incidents. Review of the Agency's Quality Improvement plan did not contain the following: (1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements; When #117 was asked how reportable incidents are reported, tracked and trended, as required by the Incident Management Quality Improvement System for Community Based Service Providers, the following was reported: #117, stated, "I usually don't" (with regards to trending). "Service Coordinators usually do the tracking, not sure if they do trending. We have incident meetings monthly then I give a presentation on how many IRs and who were involved. We don't trend, but we do track."	

Tag # 1A06 Provider Agency Policy and Procedure Requirements	Scope and Severity Rating: A	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **B. Provider Agency Policy and Procedure Requirements:** All Provider Agencies, in addition to requirements under each specific service standard shall at a minimum develop, implement and maintain, at the designated Provider Agency main office, documentation of policies and procedures for the following: (1) Coordination of Provider Agency staff serving individuals within the program which delineates the specific roles of agency staff, including expectations for coordination with interdisciplinary team members who do not work for the provider agency; (2) Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated; and (3) Agency protocols for disaster planning and emergency preparedness.	Based on interview, the Agency failed to ensure Agency Personnel were aware of the Agency's On-Call Policy & Procedures for 1 of 11 Agency Personnel. **When DSP were asked if the agency had an on-call procedure, the following was reported:** • DSP #68 stated, "They may have. I don't remember. I haven't used it. If I had a health issue I would call the PCP directly. I'm always able to find someone." (Individual #4)	Complete

Tag # 1A08 Agency Case File	Scope and Severity Rating: C	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses,	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 11 of 11 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • **Current Emergency & Personal Identification Information** ° None Found (#10) ° Did not contain Pharmacy Information (#2 & 8) ° Did not contain current address of Individual (#5) • **Annual ISP** ° Not Current (#3 & 10) • ISP Signature Page (#3, 5, 6, 7, 9 & 10) • Individual Specific Training Section (of ISP) (#3 & 10) • **ISP Teaching & Support Strategies** ° **Individual #1 - TASS not found for:** ° Outcome Statement # 1 ➢ "Cleaning schedule implemented." ➢ "Add one task as outlined above." ➢ "Add one task as identified above." ° Outcome Statement #2 ➢ "Develop a visual schedule of tasks." ➢ "Implement schedule." ➢ "GSE tasks completed with use of visual schedule only." ° Outcome Statement #4 ➢ "…will locate a beading class that she wants to participate in." ➢ "…will enroll in class." ➢ "…will complete project begun in class."	Complete

allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.	➢ "Begin process for next class." ➢ "Begin process for 3rd class." ° Outcome Statement #5 ➢ "…will identify task to participate in with Action Club." ➢ "…will identify actions to be taken to complete that task." ➢ "…will complete identified activity as scheduled." ° Outcome Statement #6 ➢ "…will identify the names and dosages of 3 of her evening medications independently." ➢ "…will identify the names and dosages of 6 of her evening medications independently." ➢ "…will identify the names and dosages of all of her evening medications independently." ➢ "…will identify the names and dosages of 3 of her morning medications independently." ➢ "…will identify the names and dosages of 6 of her evening medications independently." ➢ "…will identify the names and dosages of all of her evening medications independently." ° **Individual #3 - TASS not found for**: ° Outcome Statement #1 ➢ "...will put away 10 items in the correct location in the kitchen independently." ➢ "…will put away all household items in the correct location." ° Outcome Statement #2 ➢ "Visual schedule will be set up in the afternoon for the next day." ➢ "…will consult the visual schedule when he arrives in the morning." ➢ "…will consult the visual schedule after lunch." ➢ "…will consult the visual schedule after each activity at AH."	

	° Outcome Statement #3 ➢ "…will select the correct cleaner for windows when presented with a choice of three items." ➢ "…Will select the correct cleaner for counters when presented with a choice of three items." ➢ "…will identify the correct cleaner to use for a designated task and use it." ° Outcome Statement #4 ➢ "…will purchase a camera." ➢ "…will learn to use his camera." ➢ "…will take pictures of Aktion Club events." *[sic]* ➢ "…will edit photographs will assistance." *[sic]* ➢ "…will create photo album." ° Outcome Statement #5 ➢ "…will identify 2 different birds other than the hummingbirds and quail." ➢ "…will identify 4 different birds other than the hummingbirds and quail." ➢ "…will identify 6 different birds other than the hummingbirds and quail." ° **Individual #4 - TASS not found for:** ° Outcome Statement #1 ➢ "…will use his money to purchase items he likes or needs." ° Outcome Statement #2 ➢ "…will be given choices of what he wants to do at Day Hab." ° Outcome Statement #3 ➢ "…will research places he would like to visit." ° **Individual #5 - TASS not found for:** ° Outcome Statement #1 ➢ "…will practice tests for licenses." ➢ "…will review flash cards and manual." ➢ "…will schedule attendance for and pass a drivers' safety course."	

	➢ "…will take her written test." ° Outcome Statement #2 ➢ "…will learn the name and characteristics of 2 items monthly until entire section is learned." ° Outcome Statement #3 ➢ "…will identify a location of locations in California." *[sic]* ➢ "…will plot an itinerary." ➢ "…will determine mode of transportation." ➢ "…will determine how much she will need to save to take her trip." ➢ "…will determine how much money to save." ➢ "…will save for trip." ° **Individual #6 - TASS not found for:** ° Outcome Statement #1 ➢ "…will enroll in a computer class." ° Outcome Statement #4 ➢ "…will manage her schedule with assistive devices." ° **Individual #7 - TASS not found for:** ° Outcome Statement #1 ➢ "…will work and attend AH for one week with no more than three incidents that will be redirected by staff." ° Outcome Statement #2 ➢ "…will become involved in Photovoice." ➢ "…will select and edit photos that he might like to display." ➢ "…will select and frame/mat 5 photos for display with Photovoice or other venues." ° **Individual #9 - TASS not found for:** ° Outcome Statement #1 ➢ "Visit vegetable grower (such as Diaz Farms or other smaller farming operations)..." ➢ "Visit nurseries in area to inspect plants..."	

	➢ "Visit Farmers' Market and talk with participants about their plants and vegetables..." ➢ "Choose book on growing plants and vegetables from bookstore or library or review information on Internet at library" ➢ "Visit a community garden. Transpiration to be provided as needed" *[sic]* ➢ "Talk with landlord about growing vegetables at apartment complex. Look into possibilities of doing this, such as shiskey barrels to hold zucchini or tomatoes" *[sic]* ➢ "Plant and care for a decorative house plant" ➢ "Plant and care for a vegetable, such as zucchini, tomatoes, etc" ➢ "Harvest vegetable and choose how to prepare in a salad or side dish, as supply permits. Prepare a special meal, incorporating homegrown vegetable, and invite a friend to share" ° Outcome Statement #2 ➢ "Visit various forest areas" ➢ "gather supplies and equipment, such as gloves, trash bags, picnic lunch." ➢ "Visit chosen area for picnic lunch and gather all trash in the area into sacks." ° Outcome Statement # 3 ➢ "Visit local places where one can meet people of like interests (ex: concerts, bowling alley, four-plex, green huses, nurseries, community gardens, humane society)" *[sic]* ➢ "Introduce self to one new person monthly, such as a teacher at Penny Park." ➢ "Arrange coffee date with friend." ° **Individual #11 - TASS not found for:** ° Outcome Statement #1 ➢ "…will care for his cat with no more than 4 verbal prompts weekly." ➢ "…will complete all care tasks for his cat	

	independently." ° Outcome Statement #2 ➢ "…will print his first name on a check, document or postcard." ➢ "…will type his last name on the computer." ➢ "…will print his last name on a check, document or postcard." ➢ "…will print his first and last name on a check, document or postcard." ° Outcome Statement #3 ➢ "…will develop a resume." ➢ "…will look for employment in the community." ➢ "…will travel to his work place independently." ° Outcome Statement #4 ➢ "…will identify a route to walk to bank." ➢ "…will review street safety skills." ➢ "…will walk to bank." ➢ "…will request that his check be cashed in a consistent manner." • Positive Behavioral Plan (#1, 5 & 8) • Positive Behavioral Crisis Plan (#1, 5, 8 & 9) • Speech Therapy Plan (#1, 3 & 4) • Occupational Therapy Plan (#1, 4 & 10) • Positive Behavior Support Plan Annual Assessment (#1, 8, 10 & 11) • Positive Behavior Support Quarterlies (#1, 2, 3, 4, 8, 9, 10 & 11) • Annual Speech Therapy Assessment (#1, 3, 4, 8 & 11)	

	• Annual Occupational Therapy Assessment (#1, 6 & 10) • Annual Physical Therapy Assessment (#1) • **Written Consent by Relevant Health Decision Maker & Physician for Assistance with Medication Delivery by Staff:** ° None found Individual #1 ° None found Individual #3 ° None found Individual #5 ° None found Individual #7 ° None found Individual #9 ° None found Individual #11 • **Progress Notes written by DSP or Nurses regarding Health Status, Physical Condition and Actions Taken:** ° None found for 2/2009 - 10/2009 & 12/2009 - 2/2010 (#1) ° None found for 2/2009 - 2/2010 (#3) ° None found for 2/2009 - 2/2010 (#4) ° None found for 2/2009 - 2/2010 (#5) ° None found for 2/2009 - 2/2010 (#6) ° None found for 2/2009 - 2/2010 (#7) ° None found for 2/2009 - 2/2010 (#8) ° None found for 2/2009 - 1/2010 (#11) • Secondary Freedom of Choice ° Supported Living (#1, 8, 9 & 10) ° Family Living (#3, 4, 6 & 7) ° Independent Living (#5) ° Adult Habilitation (#1, 2, 3, 4, 6, 7, 9, 10 & 11) ° Supported Employment (#1, 2, 3, 4, 5, 7, 10 &	

	11) ° Community Access (#1, 3 & 10) ° Goods & Services (#3) ° Non-Medical Transportation (#5, 7 & 9) • Documentation of Guardianship/Power of Attorney (#2) • IDT Meeting Minutes (#2)	

Tag # 1A08 Agency Case File - Progress Notes	Scope & Severity Rating: B	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (3) Progress notes and other service delivery documentation;	Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 7 of 11 Individuals. **Supported Living Progress Notes/Daily Contact Logs** • Individual #2 - None found for 12/2009. • Individual #8 - None found for 12/15/2009. • Individual #9 - None found for 11/22/200 - 11-30/2009 & 1/1/2010 - 1/18/2010. **Adult Habilitation Progress Notes/Daily Contact Logs** • Individual #11 - None found for 12/22/2009. **Community Access Progress Notes/Daily Contact Logs** • Individual #1 - None found for 10/2009 - 12/2009. • Individual #2 - None found for 12/10/2009. • Individual #10 - None found for 11/2009 - 12/2009. **Supported Employment Progress Notes/Daily Contact Logs** • Individual #1 - None found for 10/2009 - 12/2009. • Individual #5 - None found for 8/2009 - 12/2009.	Complete

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: F	Scope and Severity Rating: D
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the	Medication Administration Records (MAR) were reviewed for the months of October, November, December 2009 and February 2010 Based on record review, 9 of 9 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #1 October 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Pantoprazole 40mg (1 time daily) – Blank 10/6, 7, 8 & 9 (8AM) • Effexor (1 time daily) – Blank 10/6, 7, 8 & 9 (8AM) • Propranolo 20mg (1 time daily) – Blank 10/6, 7, 8 & 9 (8AM) • Benzonatate 100mg (2 times daily) – Blank 10/6, 7, 8 & 9 (8AM) & 10/5, 6, 7, 8 (8PM) • Flunisolide .025% (1 time daily) – Blank 10/6, 7, 8 & 9 (8AM) • Depakote 25mg (2 times daily) – Blank 10/6, 7, 8 & 9 (8AM) & 10/5, 6, 7, 8 (8PM) • Cetirizine 10mg (1 time daily) – Blank 10/6, 7 & 8 (8AM) • Plavix 75mg (1 time daily) – Blank 10/1, 2, 6, 7 & 8 (8PM) • Zyprexa 20mg (1 time daily) – Blank 10/4, 5, 6, 7, 8 & 9 (8PM)	**New & Repeat Findings:** Medication Administration Records (MAR) were reviewed for the months of June 2010 Based on record review, 1 of 9 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #9 June 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Cotrim/Beta 1% - 0.05% Cream (2 times daily) - Blank 6/5, 6, 12, 13, 18 & 26 (9AM). • Erythromycin 2% gel (2 times daily) - Blank 6/5, 6, 12, 13, 18, 25 & 26 (9AM). • Epsom Salt (2 times daily) - Blank 6/5, 6, 12, 13, 18 & 26 (9AM).

use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications.	• Lisinopril 5mg (2 times daily) – Blank 10/6, 7, 8 & 9 (8AM) & 10/6, 7 & 8 (6PM) During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. November 2009 During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. December 2009 During on-site survey Medication Administration Records were requested for months of October, November & December 2009. As of February 10, 2010 Medication Administration Records for December 2009 had not been provided. During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. Individual #2 October 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Cymbalta 60mg (1 time daily) – Blank 10/17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (8AM) November 2009 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Xanax (Alprazolam) .05mg (3 times daily) Individual #3 October 2009 During on-site survey Medication Administration	

Model Custodial Procedure Manual ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period.	Records were requested for months of October, November & December 2009. As of February 10, 2010 Medication Administration Records for October 2009 had not been provided. During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. November 2009 During on-site survey Medication Administration Records were requested for months of October, November & December 2009. As of February 10, 2010 Medication Administration Records for November 2009 had not been provided. During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. December 2009 During on-site survey Medication Administration Records were requested for months of October, November & December 2009. As of February 10, 2010 Medication Administration Records for December 2009 had not been provided. During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. Individual #6 October 2009 During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. November 2009 During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided.	

	December 2009 During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. Individual #7 October 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Carbatrol 200mg (2 times daily) – Blank 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 & 14 (6:30AM & 6:30PM) • Carbamazepine XR 400mg (2 times daily) – Blank 10/1, 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 (6:30AM) &10/1, 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 (6:30PM) • Enalapric Maleate 10mg (2 times daily) – Blank 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 & 21 (6:30AM) &10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 & 20 (8:30PM) • Ferrous Glucomate 324mg (1 time daily) – Blank 10/1, 2, 3, 4, 5, 6, 7, 8, 9 & 10 (8:30PM) • Fexofenadine 180mg (1 time daily) – Blank 10/1, 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 (6:30PM) • Folic Acid 1mg (1 time daily) – Blank 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24 & 25 (8:30PM) • Lovastatin 40mg (1 time daily) – Blank 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18,	

	19, 20 & 21 (8:30PM) • Phenobarbital 60mg (2 times daily) – Blank 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 & 15 (6:30AM) &10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 & 14 (8:30PM) • Sertraline 100mg (1 time daily) – Blank 10/1, 2, 3, 4, 5, 6, 7, 8, 9 & 10 (6:30PM) • Warfarin 4mg (1 time daily) – Blank 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 & 16 (6:30PM) During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. November 2009 During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. December 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Carbatrol 200mg (2 times daily) – Blank 12/14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (6:30AM & 6:30PM) • Carbamazepine XR 400mg (2 times daily) – Blank 12/31 (6:30AM) &12/30 & 31 (6:30PM) • Enalapric Maleate 10mg (2 times daily) – Blank 12/21, 22, 23, 24,2 5, 26, 27, 28, 29, 30 & 31 (6:30AM) &12/20, 21, 22, 23, 24,2 5, 26, 27, 28, 29, 30 & 31 (8:30PM) • Ferrous Glucomate 324mg (1 time daily) – Blank 12/10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24,2 5, 26, 27, 28, 29, 30 & 31 (8:30PM)	

	• Fexofenadine 180mg (1 time daily) – Blank 12/27, 28, 29, 30 & 31 (6:30PM) • Folic Acid 1mg (1 time daily) – Blank 12/25, 26, 27, 28, 29, 30 & 31 (8:30PM) • Lovastatin 40mg (1 time daily) – Blank 12/21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (8:30PM) • Phenobarbital 60mg (2 times daily) – Blank 12/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (6:30AM) &12/14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (8:30PM) • Sertraline 100mg (1 time daily) – Blank 12/10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (6:30PM) • Warfarin 4mg (1 time daily) – Blank 12/16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (6:30PM) During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. Individual #8 October 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Prilosec 20mg (2 times daily) – Blank 10/1 & 2 (8AM & 5PM) Medication Administration Records did not contain the strength of the medication which is to be given: • Prenatal Plus Vitamins (1 time daily) November 2009 Medication Administration Records did not contain the strength of the medication which is to be given:	

	• Prenatal Plus Vitamins (1 time daily) December 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Carbamazepin 200mg (3 times daily) - Blank 12/22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (8AM); 12/17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (2PM) & 12/17, 18, 19 , 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (8AM) • Cetirizine 10mg (1 time daily) - Blank 12/9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (8PM) • Cymbalta (1 time daily) - Blank 12/16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (8PM) • Ethosuximide 250mg (3 times daily) - Blank 12/17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (8AM, 2PM & 8PM) • Gabapentin 600mg (4 times daily) - Blank 12/6, 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 (7AM, 12PM & 5PM) & 12/5, 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 (9:30PM) • Lorazepam 0.5mg (2 times daily) - Blank 12/9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (12PM & 8PM) • Prenatal Plus Vitamins (1 time daily) - Blank 12/4, 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 (8AM) • Prilosec 20mg (2 times daily) – Blank 12/2, 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 (8AM & 5PM) Medication Administration Records did not contain the strength of the medication which is to be given: • Prenatal Plus Vitamins (1 time daily) Individual #9 October 2009 During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. November 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Accu-Check Test Strips (3 times daily) – Blank 11/1, 4, 20, 21 & 22 (Before dinner) & 11/3 & 4 (Before lunch) • Cotrin/Beta 1% - 0.05% Cream (2 times daily) - Blank 11/25, 26 & 30 (9AM) & 11/22 (9PM) • Erythromycin 2% gel (2 times daily) - Blank 11/25, 26 & 30 (9AM) • Epsom Salt (2 times daily) - Blank 11/18, 25, 26 & 30 (9AM) & 11/22 (9PM) • Invega 6mg (1 time daily) - Blank 11/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 & 14 (9PM) • Lisinopril 10mg (1 time daily) - Blank 11/1, 2, 3, 4 & 5 (9AM) • Stool Softener 100mg (1 time daily) Blank 11/6, 12, 13, 20, 23, 28, 29 & 30 (9PM) • Trazodone 50mg & 25mg (1 time daily) Blank 11/1 & 2 (9PM)	

	During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. December 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Accu-Check Test Strips (3 times daily) – Blank 12/8, 10, 11, 12, 13, 14, 15, 19, 20, 21, 22, 23, 25, 26, 27, 28, 29, 30 & 31 (Before dinner); 12/12, 13, 19, 21, 22, 25, 26 & 27 (Before lunch) During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. February 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Accu-Check Test Strips (3 times daily) – Blank 2/7 (9AM) Individual #10 October 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Phenytonin EX 100mg (3 times daily) – Blank 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 & 21(8AM & 4PM) & 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 & 20 (9PM). November 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Aspirin 325mg (1 time daily) – Blank 11/13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (8AM)	

	• Peroxetine 30mg (1 time daily) – Blank 11/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (8AM) • Seroquel 200mg (1 time daily) – Blank 11/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (8PM) Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Omeprazole 20mg (1 time daily) December 2009 During on-site survey Medication Administration Records were requested for months of October, November & December 2009. As of February 10, 2010 Medication Administration Records for December 2009 had not been provided. Individual #11 October 2009 During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. November 2009 During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided. December 2009 During on-site survey February 8 - 10, 2010 Physician Orders were requested. As of February 10, 2010. Physician Orders had not been provided.	

Tag # 1A09 Medication Delivery - PRN Medication	Scope and Severity Rating: E	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 3 of 9 Individuals. Individual #1 October 2009 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Darvocet 100mg – PRN – 10/14, 15 & 16 (given 1 time) November 2009 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Coricidin – PRN – 11/20 (given 1 time) & 11/21 & 22 (given 2 times) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Coricidin – PRN – 11/20 (given 1 time) & 11/21 & 22 (given 2 times) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Coricidin (PRN) Medication Administration Records did not contain the strength of the medication which is to be given: • Coricidin (PRN) Individual #2 October 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Pepto Bismol (PRN)	Complete

use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed;	• Promehazine (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Pepto Bismol 1 Tablespoon – PRN – 10/6 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Pepto Bismol 1 Tablespoon – PRN – 10/6 (given 1 time) • Diphenhydram 25mg – PRN – 10/16, 17 & 18 (given 1 time) November 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Neomycin-Polymyxin B Cream (PRN) • Proctozone HC 25% (PRN) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Motrin IB 200mg – PRN – 11/13 (given 1 time) • Neomycin-Polymyxin B - PRN 11/9 & 10 (given 1 time) • Proctozone HC 25% - PRN - 11/13 (given 2 times) December 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Proctozone HC 25% (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN	

(x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period. **Department of Health** **Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006** **F. PRN Medication** 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual. 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating	medication: • Proctozone HC 25% - PRN - 12/15 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Proctozone HC 25% - PRN - 12/14, 16 & 27 (given 1 time) & 12/15 (given 3 times) Individual #8 October 2009 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Mucinex 600mg – PRN – 10/18 (given 1 time) • Tranadol 50mg – PRN – 10/1 (given 1 time) &10/1 (given 2 times) • Milk of Magnesia 5ml - PRN - 10/3 (given 1 time) • C-phen Syrup 1 - 2 tbs - PRN - 10/8 (given 1 time) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Tranadol 50mg (PRN) • Tylenol 325mg (PRN) • C-phen Syrup 1 - 2 tbs (PRN) • Milk of Magnesia 5ml (PRN) November 2009 No Signs/Symptoms was noted on the Medication Administration Record for the following PRN medication: • Neosporin - PRN - 11/12 (applied 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN	

use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN	medication: • Tranadol 50mg – PRN – 11/12 $ 14 (given 1 time) • Neosporin - PRN - 11/12 (applied 1 time) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Tranadol 50mg (PRN) • Tylenol 325mg (PRN) • C-phen Syrup 1 - 2 tbs (PRN) • Cepecol (PRN) • Milk of Magnesia 5ml (PRN) December 2009 No Signs/Symptoms was noted on the Medication Administration Record for the following PRN medication: • Milk of Magnesia - PRN - 12/10 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Milk of Magnesia - PRN - 12/10 (given 1 time) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Milk of Magnesia 5ml (PRN)	

Medications). a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).		

Tag # 1A11 (CoP) Transportation Training	Scope and Severity Rating: E	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **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: (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. **Department of Health (DOH)** **Developmental Disabilities Supports Division (DDSD) Policy** Training Requirements for Direct Service Agency	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 13 of 74 Direct Service Personnel. No documented evidence was found of the following required training: • Transportation (DSP #41, 42, 44, 64, 75, 79, 88, 89, 98, 101, 106 & 107) **When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported:** • DSP #68 stated, "I don't think so."	Complete

Staff Policy **Eff Date:** March 1, 2007 **II. POLICY STATEMENTS:** I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be 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 # 1A12 Reimbursement/Billable Units	Scope and Severity Rating: A	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed, which contained the required information for 2 of 11 individuals. Individual #4 December 2009 • The Agency billed 31 units of Family Living from 12/1/2009 through 12/31/2009. Documentation did not contain a signature/authenticated name of the staff providing the service on 12/14/2009 to justify billing. Individual #6 October 2009 • The Agency billed 22 units of Family Living from 10/1/2009 through 10/2/2009. Documentation did not contain a signature/authenticated name of the staff providing the service on 12/17/2009 to justify billing.	Complete

Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: E	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. **Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities** (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request.	Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 9 of 11 individual The following were not found, incomplete and/or not current: • Health Assessment Tool (#3, 5, 6, 7, 8 & 11) • Medication Administration Assessment Tool (#5, 6, 8 & 11) • **Quarterly Nursing Review of HCP/Crisis Plans:** ° None found for 2/2009 - 2/2010 (#1) ° None found for 2/2009 - 2/2010 (#3) ° None found for 2/2009 - 2/2010 (#5) ° None found for 2/2009 - 2/2010 (#6) ° None found for 1/2009 - 12/2009 (#7) ° None found for 2/2009 - 2/2010 (#8) ° None found for 1/2009 - 12/2009 (#11) • **Special Health Care Needs:** • Nutritional Evaluation ° Individual #9 - According to recommendation by ACT Team on 8/27/2008 the individual is required to have an evaluation. No evidence of evaluation found. ° Individual #11 - According to documentation reviewed the individual is required to have an evaluation. No evidence of evaluation found. • Meal Time Plan	Complete

(c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first. (d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy). (e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as *subjective* information including the individual complaints, signs and symptoms noted by staff, family members or other team members; *objective* information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants. **(2) Health related plans** (a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional. (b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan. (c) The nurse shall also document training regarding	° Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. ° Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. • Nutritional Plan ° Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. ° Individual #10 - As indicated by the IST section of ISP the individual is required to have a plan. • Oral Hygiene Plan ° Individual #10 - As indicated by the IST section of ISP the individual is required to have a plan. • **Health Care Plans** • HAT Level 4 ° Individual #1 - According to documentation reviewed the individual is required to have a plan. • HAT Level 5 ° Individual #8 - According to documentation reviewed the individual is required to have a plan. • Health Care Plans not Current ° Individual #7 - According to documentation reviewed the individual is required to have Health Care Plans. Plans were last reviewed by Agency 1/2007. • **Crisis Plans** • Allergies ° Individual #7 - As indicated by the IST section of ISP the individual is required to have a plan**.** ° Individual #11 - As indicated by the IST section of ISP the individual is required to have a plan.	

the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. (d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings. (3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended): (a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition. (b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal. (c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan. (d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions. (e) The nurse shall also document training on the	• Aspiration ° Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. ° Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. • Cardiac Condition ° Individual #7 - As indicated by the IST section of ISP the individual is required to have a plan. ° Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. • COPD ° Individual #11 - As indicated by the IST section of ISP the individual is required to have a plan. • Diabetes ° Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. • Falls ° Individual #7 - As indicated by the IST section of ISP the individual is required to have a plan. • Gastrointestinal ° Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. • History of Substance Abuse ° Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. • Seizures ° Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. ° Individual #7 - As indicated by the IST section of ISP the individual is required to have a plan.	

healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings. (f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization. (g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author. (h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed. **(4) General Nursing Documentation** (a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person. (b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.	° Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan**.**	

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: D	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff…	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 2 of 74 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Person-Centered Planning (1-Day) (DSP #82) • Positive Behavior Supports Strategies (DSP #68) • Participatory Communication & Choice Making (DSP #68) • Level 1 Health (DSP #68) • Rights & Advocacy (DSP #68) • Teaching & Support Strategies (DSP #68)	Complete

Tag # 1A22 Staff Competence	Scope and Severity Rating: E	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **F. Qualifications for Direct Service Personnel:** The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency: (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and	Based on interview, the Agency failed to ensure that training competencies were met for 6 of 11 Direct Service Personnel. **When DSP were asked if the individual had a Positive Behavioral Crisis Plan and what the plan covered, the following was reported:** • DSP #77 reported not being sure if the Individual had a Positive Behavioral Crisis Plan. According to the Individual Specific Training Section of the ISP, the individual has Positive Behavioral Crisis Plan). (Individual #5) **When DSP were asked if they received training on the Individual's Speech Therapy Plan and what the plan covered, the following was reported:** • DSP #43 stated, "…not seen." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #6) **When DSP were asked if they received training on the Individual's Occupational Therapy Plan and what the plan covered, the following was reported:** • DSP #97 reported they had not seen an Occupational Therapist, According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #1) • DSP #43 stated, "Haven't seen it." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #6) **When DSP were asked if they received training on the Individual's Physical Therapy Plan and what**	Complete

(5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support. (6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows: (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff.	**the plan covered, the following was reported:** • DSP #105 stated, "I don't know." According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan. (Individual #1) **When DSP were asked if they received training on the Individual's Health Care Plans and what the plan covered, the following was reported:** • DSP #105 stated, "She doesn't have any." As indicated by the Agency file, the Individual has Health Care Plans for Aspiration, Self-Esteem, Sensory Perception, Hyperlipdemia, Constipation and UTI's. (Individual #1) • DSP #103 stated, "No. Haven't seen them." As indicated by the Agency file, the Individual has Health Care Plans for Seizures. (Individual #7) **When DSP were asked if they received training on the Individual's Crisis Plans and what the plan covered, the following was reported:** • DSP #105 stated, "She doesn't have any." As indicated by the Agency file, the Individual has Crisis Plans for Aspiration, Seizures & Tardive Dyskinesia. (Individual #1) • DSP #43 stated, "No." As indicated by the Agency file, the Individual has Crisis Plans for diabetes. (Individual #6) • DSP #103 stated, "No. Haven't seen them." As indicated by the Agency file, the Individual has Crisis Plans for Seizures. (Individual #7) **When DSP were asked if they had received training regarding the individual's Seizure Disorder and if seizure logs were kept, the following was reported:**	

	• DSP #90 stated, "No," (seizure logs were kept.) When asked how new staff are trained on the Individual's seizures, DSP stated, "I'm not sure." According to the ISP, the individual has a diagnosis of Seizures. (Individual #10) **When DSP were asked if they had received training on the Individual's Diabetes, the following was reported:** • DSP #43 stated, "Not specific training for diabetes." When asked about signs of high blood sugar, DSP stated, "Not sure". When asked what to do if there is high blood sure, DSP stated, "Not sure." (Individual #6) **When DSP were asked to describe the signs and symptoms of an adverse reaction to a medication, the following was reported:** • DSP #77 stated, "Pick skin off, eyes dilated, lose or gain weight." (Individual #5) **When DSP were asked to describe the signs and symptoms of an allergic reaction to food, the following was reported:** • DSP #105 stated, "I wouldn't know." (Individual #1)	

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D	Scope and Severity Rating: N/A
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:** **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11** **DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.	Based on record review, the Agency failed to maintain documentation indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 1 of 77 Agency Personnel. The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings: • #106 – Date of hire 6/18/2009	Complete

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: D	Scope and Severity Rating: N/A
NMAC 7.1.12.8 **REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED**: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals	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 5 of 77 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** • #75 – Date of hire 8/28/2006. Completed 9/7/2006. • #77 – Date of hire 2/23/2009. Completed 10/23/2009. • #104 – Date of hire 11/14/2009. Completed 11/25/2009. • #111 – Date of hire 12/9/2009. Completed 12/10/2009. • #115 – Date of hire 8/12/2008. Completed 8/13/2008.	Complete

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.		

Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: E	Scope and Severity Rating: D
7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: **A. Duty To Report:** **(1)** All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. **(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: **(a)** an environmental hazardous condition, which creates an immediate threat to life or health; or **(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. **(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. **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.	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 8 of 15 individuals. Individual #1 • Incident date 5/11/2009. Allegation was Neglect. Incident report was received 5/11/2009. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." • Incident date 10/15/2009. Allegation was Abuse and Neglect. Incident report was received 10/20/2009. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #2 • Incident date 3/26/2009. Allegation was Neglect. Incident report was received 4/2/2009. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #9 • Incident date 8/31/2009. Allegation was Neglect. Incident report was received 9/4/2009. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #11 • Incident date 9/7/2009. Allegation was Neglect. Incident report was received 9/9/2009. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #12 • Incident date 3/27/2009. Allegation was Neglect. Incident report was received 3/27/2009. Failure to Report. IMB Late & Failure Report indicated	**New & Repeat Findings:** 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 3 of 17 individuals. Individual #1 • Incident date 4/8/2010. Allegation was Neglect. Incident report was received 4/9/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #16 • Incident date 3/31/2010. Allegation was Neglect. Incident report was received 4/8/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #17 • Incident date 6/9/2010. Allegation was Neglect. Incident report was received 6/10/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."

	incident of Neglect was “Confirmed.” Individual #13 • Incident date 3/26/2009. Allegation was Neglect. Incident report was received 4/2/2009. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was “Confirmed.” Individual #14 • Incident date 8/20/2009. Allegation was Neglect. Incident report was received 8/21/2009. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was “Confirmed.” • Incident date 11/1/2009. Allegation was Neglect. Incident report was received 11/9/2009. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was “Confirmed.” Individual #15 • Incident date 9/7/2009. Allegation was Neglect. Incident report was received 9/9/2009. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was “Confirmed.”	

Tag # 1A28 (CoP) Incident Mgt. System - Policy & Procedure	Scope & Severity Rating: F	Scope and Severity Rating: N/A
7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: **C. Incident Policies:** All community based service providers shall maintain policies and procedures, which describe the community based service provider's immediate response to all reported allegations of incidents involving abuse, neglect, or misappropriation of property; all unexpected deaths or natural/expected deaths, and other reportable incidents required as required in Paragraph (2) of Subsection A of 7.1.13.9 NMAC. **NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **B. Training Curriculum:** The licensed health care facility and community based service provider shall provide all employees and volunteers with a written training curriculum on incident policies and procedures for identification, and timely reporting of abuse, neglect, misappropriation of consumers' property, and where applicable to community based service providers, unexpected deaths or other reportable incidents, within thirty (30) days of the employees' initial employment, and by annual review not to exceed twelve (12) month intervals. The training curriculum may include computer-based training. Periodic reviews shall include, at a minimum,	Based on record review the Agency failed to establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. During on-site survey, the following was found: • Review of the Agency's Policy and Procedure, "1.21 Incident Management Procedure," it was found not to be current. It was last reviewed on 8/18/2005. The reporting numbers listed were not current. Reporting numbers did not match current numbers on the IMB reporting posters and IR forms.	Complete

review of the written training curriculum and site-specific issues pertaining to the licensed health care facilities or community based service provider's facility. Training shall be conducted in a language that is understood by the employee and volunteer. **C. Incident Management System Training Curriculum Requirements:** **(1)** The licensed health care facility and community based service provider shall conduct training, or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum that includes but is not limited to: **(a)** an overview of the potential risk of abuse, neglect, misappropriation of consumers' property; **(b)** informational procedures for properly filing the division's incident management report form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and misappropriation of consumers' property. **(d)** specific instructions on how to respond to abuse, neglect, misappropriation of consumers' property; **(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, misappropriation of consumers' property; and **(f)** where applicable to employees of community based service providers, informational procedures for properly filing the division's incident management report form for unexpected deaths or other reportable incidents.		

Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: E	Scope and Severity Rating: N/A
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007** **II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.	Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 16 of 77 Agency Personnel. • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#52, 55, 64, 65, 66, 68, 86, 88, 89, 103, 104, 106 & 112) **When DSP were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect & Misappropriation of Consumers' Property, the following was reported:** • DSP #73 stated, “Can’t remember.” • DSP #77 did not state DHI. • DSP #41 stated, “It’s in Santa Fe. I have it in my book.” Card presented to Surveyors was not relevant to Incident Management reporting.	Complete

Tag # 1A28 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: E	Scope and Severity Rating: N/A
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **E. Consumer and Guardian Orientation Packet:** Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 9 of 11 individuals. • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#1, 3, 4, 5, 6, 7, 8, 9 & 11)	Complete

Tag # 1A28 (CoP) Incident Mgt. System - Posters	Scope & Severity Rating: D	Scope and Severity Rating: N/A
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **F. Posting of Incident Management Information Poster:** All licensed health care facilities and community based service providers shall post two (2) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. All licensed health care facilities and community based service providers operating sixty (60) or more beds shall post three (3) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. The posters shall be posted where employees report each day and from which the employees operate to carry out their activities. Each licensed health care facility or community based service provider shall take steps to insure that the notices are not altered, defaced, removed, or covered by other material. [7.1.13.10 NMAC - N, 02/28/06]	Based on observation, the Agency failed to post two (2) or more Incident Management Information posters in a prominent public location for the following locations for 1 of 9 residences: The following locations were identified: Residence of : • Individual #10	Complete

Tag # 1A29 Complaints / Grievances - Acknowledgement	Scope and Severity Rating: B	Scope and Severity Rating: N/A
NMAC 7.26.3.6 A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's complaint or grievance procedure	Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 6 of 11 individuals. • Grievance/Complaint Procedure Acknowledgement (#3, 4, 8, 9, 10 & 11)	Complete

Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: F	Scope and Severity Rating: N/A
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] **Long Term Services Division** **Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003** **IV. POLICY STATEMENT -** Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is	Based on record review, the Agency failed to follow DDSD Policy regarding Human Rights Committee Requirements. The Agency's policy & procedure stated, the following: A review of Agency's Policy & Procedure, "Human Rights Committee," found it did not discuss The purpose of the committee with respect to the provision of Behavior Supports, in terms of reviewing and monitoring the implementation of certain Behavior Support Plans and restrictions.	Complete

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: F	Scope and Severity Rating: N/A
NMAC 7.26.5.16.C and D **Development of the ISP. Implementation of the ISP.** The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 11 of 11 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • None found for 10/2009 - 12/2009. Individual #2 • None found for 8/2009 - 12/2009. Individual #8 • None found for 2/2009 - 2/2010. Individual #9 • None found for 10/2009 - 12/2009. Individual #10 • None found for 10/2009 - 1/2010. **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #3 • None found for 1/2009 - 12/2009 Individual #4 • None found for 10/2009 - 12/2009 Individual #6 • None found for 8/2009 - 12/2009 Individual #7 • None found for 1/2009 - 12/2009	Complete

	Independent Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes: Individual #5 • None found for 8/2009 - 12/2009 Individual #11 • None found for 10/2009 - 12/2009 **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • None found for 10/2009 - 12/2009 Individual #2 • None found for 8/2009 - 12/2009. Individual #3 • None found for 1/2009 - 12/2009 Individual #4 • None found for 10/2009 - 12/2009 Individual #6 • None found for 8/2009 - 12/2009 Individual #7 • None found for 1/2009 - 12/2009 Individual #8 • None found for 2/2009 - 2/2010. Individual #9 • None found for 10/2009 - 12/2009. Individual #10 • None found for 10/2009 - 1/2010. Individual #11 • None found for 10/2009 - 12/2009	

	Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes: Individual #1 • None found for 2/2009 - 2/2010 Individual #2 • None found for 8/2009 - 12/2009. Individual #3 • None found for 1/2009 - 12/2009 Individual #4 • None found for 10/2009 - 12/2009 Individual #5 • None found for 8/2009 - 12/2009 Individual #7 • None found for 1/2009 - 12/2009 Individual #10 • None found for 10/2009 - 1/2010. Individual #11 • None found for 10/2009 - 12/2009 **Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • None found for 2/2009 - 2/2010 Individual #2 • None found for 8/2009 - 12/2009. Individual #3 • None found for 1/2009 - 12/2009 Individual #10 • None found for 10/2009 - 1/2010.	

Tag # 1A33 Board of Pharmacy - Med Storage	Scope and Severity Rating: A	Scope and Severity Rating: N/A
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual - E. Medication Storage: 1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee. 2. Drugs to be taken by mouth will be separate from all other dosage forms. 3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature. 4. Separate compartments are required for each resident's medication. 5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day. 6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist. **8. References -** A. Adequate drug references shall be available for facility staff **H. Controlled Substances (Perpetual Count Requirement)** 1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance, indicating the following information: a. date b. time administered c. name of patient d. dose e. practitioner's name	Based on observation, the Agency failed to ensure proper storage of medication for 2 of 11 individuals. Observation included: Individual #1 • Lorazepam 1mg - PRN - Was not stored in a locked cabinet, as per regulation. Individual #3 • Eye Drops were not kept separate from medications taken by mouth.	Complete

f. signature of person administering or assisting with the administration the dose g. balance of controlled substance remaining.		

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: D	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (2) **Individual-specific training** for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** **A.** Individuals shall receive services from competent and qualified staff. **B.** Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.	Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 12 of 77 Agency Personnel. Review of personnel records found no evidence of the following: • Individual Specific Training (#68, 72, 75, 79, 88, 89, 99, 104, 106, 112, 115 & 116)	Complete

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Scope and Severity Rating: C	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **E. Provider Agency Reporting Requirements:** All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD.	Based on record review, the Agency failed to complete quarterly reports as required for 11 of 11 individuals receiving Community Inclusion services. **Adult Habilitation Quarterly Reports** • Individual #1 - None found for 2/2009 - 2/2010 • Individual #2 - None found for 2/2009 - 2/2010 • Individual #3 - None found for 1/2009 - 12/2009 • Individual #4 - None found for 2/2009 - 2/2010 • Individual #6 - None found for 1/2009 - 10/2009 • Individual #7 - None found for 1/2009 - 12/2009 • Individual #8 - None found for 2/2009 - 2/2010 • Individual #9 - None found for 2/2009 - 2/2010 • Individual #10 - None found for 2/2009 - 2/2010 • Individual #11 - None found for 5/2009 - 12/2009 **Community Access Quarterly Reports** • Individual #1 - None found for 2/2009 - 2/2010 • Individual #2 - None found for 2/2009 - 2/2010 • Individual #3 - None found for 1/2009 - 12/2009 • Individual #10 - None found for 2/2009 - 2/2010 **Supported Employment Quarterly Reports** • Individual #1 - None found for 2/2009 - 2/2010 • Individual #2 - None found for 2/2009 - 2/2010	Complete

	• Individual #3 - None found for 1/2009 - 12/2009 • Individual #4 - None found for 2/2009 - 2/2010 • Individual #5 - None found for 6/2009 - 12/2009 • Individual #7 - None found for 1/2009 - 12/2009 • Individual #10 - None found for 2/2009 - 2/2010 • Individual #11 - None found for 5/2009 - 12/2009	

Tag # 5I22 SE Agency Case File	Scope and Severity Rating: B	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS** **D. Provider Agency Requirements** (1) Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDSD. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits. (2) The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items: (a) Quarterly progress reports; (b) Vocational assessments (A vocational assessment or profile is an objective analysis of a person's interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDSD; (c) Career development plan as incorporated in the ISP; a career development plan consists of the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks including the individual, as well and a review and reporting	Based on record review, the Agency failed to maintain a confidential case file for each individual for 4 of 8 individuals receiving Supported Employment Services. The following were not found, incomplete and/or not current: • Vocational Assessment (#11) • Required Certificates & Documentation ◦ Check Stub and/or Time Study (#5, 7, 10 & 11)	Complete

mechanism for mutual accountability; and (d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973. New Mexico Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy **Policy Title: Vocational Assessment Profile** **Policy Eff July 16, 2008** **I. PURPOSE** The intent of the policy is to ensure that individuals are identified who could benefit from Vocational Assessment Profiles (VAPs) and are supported to access this support. **II. POLICY STATEMENT** Individuals served under the Developmental Disabilities Medicaid Waiver (DDW) who express an interest in obtaining employment or exploring employment opportunities, or individuals who desire a VAP and those whose teams identify that they could benefit from a VAP, will have access to a VAP in accordance to the DDW Service Standards and related procedures.		

Tag # 5I25 SE Reimbursement	Scope and Severity Rating: A	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS** **E. Reimbursement** (1) Billable Unit: (a) Job Development is a single flat fee unit per ISP year payable once an individual is placed in a job. (b) The **billable unit for Individual Supported Employment** is one hour with a maximum of four hours a month. The Individual Supported Employment hourly rate is for face-to-face time which is supported by non face-to-face activities as specified in the ISP and the performance based contract as negotiated annually with the provider agency. Individual Supported Employment is a minimum of one unit per month. If an individual needs less then one hour of face-to-face service per month the IDT Members shall consider whether Supported Employment Services need to be continued. Examples of non face-to-face services include: (i) Researching potential employers via telephone, Internet, or visits; (ii) Writing, printing, mailing, copying, emailing applications, resume, references and corresponding documents; (iii) Arranging appointments for job tours, interviews, and job trials; (iv) Documenting job search and acquisition progress; (v) Contacting employer, supervisor, co-workers and other IDT team members to assess individual's progress, needs and satisfaction; and (vi) Meetings with individual surrounding job development or retention not at the employer's site. (c) Intensive Supported Employment services are intended for individuals who need one-to-one, face-	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 1 of 8 individuals Individual #2 October 2009 • The Agency billed 15 units of Supported Employment from 10/1/2009 through 10/31/2009. Documentation received accounted for 8 units. November 2009 • The Agency billed 13 units of Supported Employment from 11/1/2009 through 11/30/2009. Documentation received accounted for 8 units.	Complete

to-face support for 32 or more hours per month. The billable unit is one hour. (d) Group Supported Employment is a fifteen-minute unit. (e) Self-employment is a fifteen minute unit. (4) Billable Activities include: (a) Activities conducted within the scope of services; (b) Job development and related activities for up to ninety (90) calendar days) that result in employment of the individual for at least thirty (30) calendar days; and (c) Job development services shall not exceed ninety (90) calendar days, without written approval from the DDSD Regional Office.		

Tag # 5I36 CA Reimbursement	Scope and Severity Rating: A	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS** **G. Reimbursement** (1) Billable Unit**:** A billable unit is defined as one-quarter hour of service. (2) Billable Activities**:** The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan; (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and (c) Non face-to-face hours do not exceed 10% of the monthly billable hours. (3) Non-Billable Activities**:** Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include: (a) Time and expense for training service personnel; (b) Supervision of agency staff; (c) Service documentation and billing activities; or (d) Time the individual spends in segregated facility-based settings activities.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 1 of 5 individuals. Individual #2 December 2009 • The Agency billed 6 units of Community Access on 12/10/2009. No documentation found to justify billing.	Complete

Tag # 5I44 AH Reimbursement	Scope and Severity Rating: B	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XVI. REIMBURSEMENT** **A. Billable Unit**. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care. **B. Billable Activities** (1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours. (2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 4 of 10 individuals. Individual #1 November 2009 • The Agency billed a total of 458 units of Adult Habilitation from 11/1/2009 through 11/30/2009. Documentation received accounted for 436 units. Documentation for 11/18/2009 indicated the Individual was with the OT from 8:45AM - 3PM. Individual #2 October 2009 • The Agency billed a total of 465 units of Adult Habilitation from 10/1/2009 through 10/31/2009. Documentation received accounted for 304 units. Individual #8 October 2009 • The Agency billed a total of 528 units of Adult Habilitation from 10/1/2009 through 10/31/2009. Documentation received accounted for 429 units. Individual #11 October 2009 • The Agency billed a total of 428 units of Adult Habilitation from 10/1/2009 through 10/31/2009. Documentation received accounted for 409 units. November 2009 • The Agency billed a total of 371 units of Adult Habilitation from 11/1/2009 through 11/30/2009. Documentation received accounted for 348 units. December 2009 • The Agency billed a total of 258 units of Adult Habilitation from 12/1/2009 through 12/19/2009. Documentation received accounted for 220 units.	Complete

	• The Agency billed 12 units of Adult Habilitation from on 12/22/2009. No documentation found to justify billing.	

Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: F	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES** **B. Home Studies**. The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS** **D. Scope of DDSD Agreement** (4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite; **NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER - ELIGIBLE PROVIDERS:** I. **Qualifications for community living service providers:** There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards. (1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or	Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 4 of 4 individuals. The following was not found, not current and/or incomplete: • DDSD Approval for Subcontractor (#3, 4, 6 & 7) • Family Living (Initial) Home Study (#6) • Family Living (Annual Update) Home Study (#3, 4 & 7) • Current Family Living Contract (#3, 4, 6 & 7)	Complete

subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.		

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6	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 6 of 11 individuals receiving Community Living Services. • **Annual Physical** (#3, 4, 6, 8 & 9) • **Dental Exam** ° Individual #4 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ° Individual #6 - As indicated by the ancillary documentation reviewed, exam was reported as completed on 6/18/2007. No evidence of exam was found. ° Individual #8 - As indicated by the ancillary documentation reviewed, exam was reported as completed on 11/26/2008. No evidence of exam was found. • **Vision Exam** ° Individual #2 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #4 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° 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 #9 - As indicated by the documentation reviewed, exam was completed on 11/2005. Follow-up was to be completed in one year. No evidence of follow-up found.	Complete

on the HAT, has a Health Care Plan developed by a licensed nurse. (c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition. (4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT. (5) That the physical property and grounds are free of hazards to the individual's health and safety. (6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following: (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).	• **Auditory Exam** ° Individual #6 - As indicated by the documentation reviewed, exam was completed on 8/31/2006. Follow-up was to be completed in one year. No evidence of follow-up found. ° Individual #9 - As indicated by the documentation reviewed, exam was completed on 10/7/1997. A "retest" was to be completed. No evidence of retest found. ▪ **Cholesterol & Blood Glucose** ° Individual #6 - As indicated by the documentation reviewed, the individual requires lab work for diabetes, as Individual #6 takes Glucophage. No evidence found to verify lab work was completed. • **Review of Psychotropic Medication** ° Individual #9 - According to documentation reviewed Individual #9 is to have a medication reviewed. No evidence was found for the following time frame to indicate they were completed (2/2009 - 1/2010). • **Records of visits to Health Care & Psychiatric Practitioners Including Treatment Provided** (#4)	

Tag # 6L14 Residential Case File	Scope and Severity Rating: F	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of a physician's or qualified health care provider's	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 9 of 9 Individuals receiving Family Living Services or Supported Living Services. The following was not found, incomplete and/or not current: • **Current Emergency & Personal Identification Information** ° Did not contain Pharmacy Information (#10) • Annual ISP (#1, 2, 3, 6, 7, 8 & 10) • Individual Specific Training (#1, 2, 3, 6, 7, 8 & 10) • Teaching & Support Strategies (#1, 2, 3, 6, 7, 8, 9 & 10) • Positive Behavioral Plan (#1, 4, 8 & 9) • Positive Behavioral Crisis Plan (#8) • Speech Therapy Plan (#1, 4, 6 & 8) • Occupational Therapy Plan (#4, 6, 8, 9 & 10) • Physical Therapy Plan (#4) • **Special Health Care Needs** ° Meal Time Plan (#1 & 3) ° Nutritional Plan (#10) • **Health Care Plans** ° Constipation (#1) ° GERD (#1) ° Hyperlipdemia (#1) ° Self Esteem (#1) ° Sensory Perception (#1) ° Urinary Tract Infection (#1)	Complete

order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months,	• **Crisis Plan** ° Aspiration (#1, 3 & 9) ° Diabetes (#6) ° Seizures (#1 & 7) ° Tardive Dyskinesia (#1) • **Progress Notes/Daily Contacts Logs:** ° Individual #1 - None found for February 1 - 6, 2010. ° Individual #3 - None found for February 1 - 8, 2010. ° Individual #9 - None found for February 1 - 9, 2010. • **Data Collection/Data Tracking:** ° Individual #1 - None found for February 1 - 8, 2010 ° Individual #3 - None found for February 1 - 8, 2010. ° Individual #4 - None found for February 1 - 8, 2010. ° Individual #8 - None found for February 1 - 9, 2010. ° Individual #9 - None found for February 1 - 9, 2010. • **Progress Notes written by DSP and/or Nurses regarding Health Status:** ° Individual #3 - None found for February 1 - 8, 2010. ° Individual #9 - None found for February 1 - 9, 2010.	

past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.	• **Health Care Providers Written Orders** (#4 & 6) • **Record of visits of healthcare practitioners** (#4 & 6) • **Grievance/Complaint Procedure Acknowledgement** (#1, 3 & 10)	

Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports)	Scope and Severity Rating: C	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **D. Community Living Service Provider Agency Reporting Requirements:** All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation: (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members.	Based on record review, the Agency failed to complete written quarterly status reports for 11 of 11 individuals receiving Community Living Services. **Supported Living Quarterly Reports:** • Individual #1 - None found for 2/2009 - 2/2010 • Individual #2 - None found for 2/2009 - 2/2010 • Individual #8 - None found for 2/2009 - 2/2010 • Individual #9 - None found for 2/2009 - 2/2010 • Individual #10 - None found for 2/2009 - 2/2010 **Family Living Quarterly Reports:** • Individual #3 - None found for 1/2009 - 12/2009 • Individual #4 - None found for 2/2009 - 2/2010 • Individual #6 - None found for 1/2009 - 10/2009 • Individual #7 - None found for 1/2009 - 12/2009 **Independent Living Quarterly Report:** • Individual #5 - None found for 6/2009 - 12/2009 • Individual #11 - None found for 5/2009 - 12/2009	Complete

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

	individual's ISP (#3, 4, 6 & 7)	

Tag # 6L25 (CoP) Residential Reqts. (Physical Environment - Supported Living & Family Living)	Scope and Severity Rating: D	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services** (2) Overall each residence shall maintain basic utilities, i.e., gas, power, water, telephone at the residence and shall maintain the physical environment in a safe and comfortable manner for the individuals. (3) Each individual shall have access to all household equipment and cleaning supplies unless precluded by his or her ISP. (4) Living and Dining Areas shall (a) Provide individuals free use of all space with due regard for privacy, personal possessions and individual interests; (b) Maintain areas for the usual functions of daily living, social, and leisure activities in a clean and sanitary condition; and (c) Provide environmental accommodations based on the unique needs of the individual. (5) Kitchen area shall: (a) Possess equipment, utensils, and supplies to properly store, prepare, and serve at least three (3) meals a day; (b) Arrangements will be made, in consultation with the IDT for environmental accommodations and assistive technology devices specific to the needs of the individual(s); and (c) Water temperature is required to be maintained at a safe level to both prevent	Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard, which maintains a physical environment which is safe and comfortable for 2 of 9 Supported Living & Family Living residences. **Supported Living Requirements:** During on-site visits surveyors observed the following: During the Home Visit at Individual #1's home on 2/8/2010 the following areas of concern were found: • Individual #1's bathroom shower was not working at the time of the visit. The Individual reported needing assistance to get into the "staff" shower. It was additionally reported that the landlord was aware of the issue, however, there was no evidence found to indicate what is being done to address the concern. During the Home Visit at Individual #10's home on 2/11/2010 the following areas of concern were found: • Individual #10's bedroom door has the hinges pulled out of the frame. Individual #10 reported he can not/does not close the door because of this issue. Additionally, there are weak spots in the hallway floor near the backdoor. The floor depressed approximately 2 inches when stepped on. It is covered by new linoleum sheeting. This sheeting has a gap at the end of the hall near the computer room. Causing a potential trip hazard. Another weak spot in the floor was identified surrounding the toilet used by staff in the rear of the residence.	Complete

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

Tag # 6L26 SL Reimbursement	Scope and Severity Rating: B	Scope and Severity Rating: N/A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES** A. **Reimbursement** for Supported Living Services (1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year. (2) **Billable Activities** (a) Direct care provided to an individual in the residence any portion of the day. (b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community. (c) Any activities in which direct support staff provides in accordance with the Scope of Services. (3) Non-Billable Activities (a) The Supported Living Services provider shall not bill DD Waiver for Room and Board. (b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services. (c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 3 of 5 individuals. Individual #2 December 2009 • The Agency billed 31 units of Supported Living from 12/1/2009 through 12/31/2009. No documentation found to justify billing. Individual #8 December 2009 • The Agency billed 31 units of Supported Living from 12/1/2009 through 12/31/2009. Documentation received accounted for 30 units. No documentation was found for December 15, 2009. Individual #10 December 2009 • The Agency billed 26 units of Supported Living from 12/1/2009 through 12/31/2009. Documentation received accounted for 25 units. No documentation was found for December 9, 2009.	Complete