Date: January 12, 2011

To: Diane Nunn, Executive Director
Provider: The New Beginnings LLC
Address: 8908 Washington St. NE Albuquerque
State/Zip: New Mexico 87113

E-mail Address: dnunn@tnbabq.com

Region: Metro & Southwest
Survey Date: November 15 - 19, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living, Independent Living & Family Living) & Community Inclusion (Adult Habilitation & Community Access)
Survey Type: Routine
Team Leader: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Cynthia Nielsen, MSN, RN, ONC, CCM, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Crystal Lopez-Beck, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Maurice Gonzales, BS of Health Ed., Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Regina Lewis, Social and Community Service Coordinator, Developmental Disabilities Supports Division & Zack Robinson, Social and Community Service Coordinator, Developmental Disabilities Supports Division

Dear Ms. Nunn;

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

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

Plan of Correction:
The attached Report of Findings identifies deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. See attachment "A" for additional guidance in completing the Plan of Correction. The response is due to the parties below within 10 working days of the receipt of this letter:

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

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

Upon notification from QMB that your Plan of Correction has been approved, you must implement all remedies and corrective actions within 45 working days. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as all remedies must still be completed within 45 working days of the receipt of this letter.

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

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

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

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

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

Sincerely,

Tony Fragua, BFA

Tony Fragua, BFA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	November 15, 2010
Present:	**The New Beginnings, LLC** Diane Nunn, Executive Director Ken Sangha, Operations Manager Jackie Devizio, Human Resource Manager **DOH/DHI/QMB** Tony Fragua, BFA, Team Lead/Healthcare Surveyor Cynthia Nielsen, MSN, RN, ONC, CCM, Healthcare Surveyor Marti Madrid, LBSW, Healthcare Surveyor Maurice Gonzales, BS of Health Ed., Healthcare Surveyor Deb Russell, BS, Healthcare Surveyor **DDSD – Metro & SW Regional Office** Regina Lewis, Social and Community Service Coordinator Zack Robinson, Social and Community Service Coordinator
Exit Conference Date:	November 19, 2010
Present:	**The New Beginnings, LLC** Diane Nunn, Executive Director Ken Sangha, Operations Manager Desiree Martinez, RN Dan Davis, Service Coordinator Marc Lacroix, Service Coordinator Molli Bass, Documentation Manager Annette Acosta-Moya, Service Coordinator Nicole Berezin, Trainer Jackie Devizio, Human Resource Manager Aspen Hamilton, Office Staff Kelly G. Walker, Quality Assurance Colene Fields, LPN Lori Washburn, Service Coordinator **DOH/DHI/QMB** Tony Fragua, BFA, Team Lead/Healthcare Surveyor Crystal Lopez-Beck, BS, Healthcare Surveyor Cynthia Nielsen, MSN, RN, ONC, CCM, Healthcare Surveyor Maurice Gonzales, BS of Health Ed., Healthcare Surveyor **DDSD - Metro Regional Office** Regina Lewis, Social and Community Service Coordinator
Total Homes Visited	Number: 23
❖ Supported Homes Visited	Number: 5 (2 individuals live in one home)
❖ Family Homes Visited	Number: 18
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 27 3 - *Jackson* Class Members 24 - Non-*Jackson* Class Members 6 - Supported Living 18 - Family Living 3 - Independent Living 12 - Adult Habilitation

4 - Community Access

Persons Served Interviewed	Number:	22
Persons Served Observed	Number:	5 (1 individual was unavailable for interview; 1 individual declined to be interviewed and 3 individuals didn't respond to Surveyors questions).
Direct Service Personnel Interviewed	Number:	37
Records Reviewed (Persons Served)	Number:	27

Administrative Files Reviewed

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

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

Attachment A

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

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

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

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

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

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

Instructions for Completing Agency POC:

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

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

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

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

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

5. The individual's title responsible for the Plan of Correction and completion date.

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

Completion Dates

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

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

Plan of Correction Submission Requirements

1. Your Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. If you have questions about the POC process, call the POC Coordinator, George Perrault at 505-222-8647 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to George Perrault, POC Coordinator in any of the following ways:
    a. Electronically at George.Perrault@state.nm.us
    b. Faxed to 505-222-8661, or
    c. Mailed to QMB, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not send supporting documentation to QMB until after your POC has been approved by QMB.
6. QMB will notify you when your POC has been "approve" or "denied."
    a. Whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
    b. If your POC is "Denied" it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
    c. If your POC is "Denied" a second time your agency may be referred to the Internal Review Committee.
    d. You will receive written confirmation that your POC has been approved by QMB and a final deadline for completion of your POC.

7. Failure to submit your POC within 10 days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.
8. Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

POC Document Submission Requirements

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

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

Attachment B

QMB Scope and Severity Matrix

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

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

Scope and Severity Definitions:

- Isolated:

A deficiency that is limited to 1% to 15% of the sample, usually impacting few individuals in the sample.

- Pattern:

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

- Widespread:

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

QMB Determinations of Compliance

- "Substantial Compliance with Conditions of Participation"

The QMB determination of "Substantial Compliance with Conditions of Participation" indicates that a provider is in substantial compliance with all 'Conditions of Participation' and other standards and regulations. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Substantial Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation.

- "Non-Compliance with Conditions of Participation"

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

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

- "Sub-Standard Compliance with Conditions of Participation":

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

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

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

Attachment C

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

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

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final report.

2. The written request for an IRF must be completed on the QMB Request for Informal Reconsideration of Finding Form available on the QMB website: http://dhi.health.state.nm.us/qmb

3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.

4. The IRF request must include all supporting documentation or evidence.

The following limitations apply to the IRF process:

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

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

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

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

Agency: **The New Beginnings, LLC – Metro & Southwest Regions**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living, Family Living & Independent Living) & Community Inclusion (Adult Habilitation & Community Access)
Monitoring Type: Routine Survey
Date of Survey: **November 15 - 19, 2010**

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A08 Agency Case File	**Scope and Severity Rating: 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	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 3 of 27 individuals. Review of the Agency individual case files found the following items were not found, incomplete, and/or not current: • **ISP Teaching & Support Strategies** ◦ Individual #13 - TASS not found for: ◦ Outcome Statement # 3 ➢ "Research the internet, activity calendar for community events, newspaper and Alibi." ◦ Individual #19 - TASS not found for: ◦ Outcome Statement # 1 "will get a low-rider vehicle and ride 10 different trails" ➢ "will ride 10 different trails" ◦ Outcome Statement # 2 "will volunteer at a ranch or a farm taking care of animals for one year" ➢ "will volunteer at a ranch or farm" ◦ Outcome Statement # 3 "will visit his brother once" ➢ "be reintroduced to brothers through pictures" ◦ Outcome Statement # 4 "will participate in		

all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.	Special Olympics for track" ➢ "will practice running" ➢ "will participate in Special Olympics" • Positive Behavioral Plan (#15) • Positive Behavioral Crisis Plan (#15) • Speech Therapy Plan (#13 & 19) • Occupational Therapy Plan (#19)		

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and	Medication Administration Records (MAR) were reviewed for the months of July, August, September & November 2010. Based on record review, 13 of 22 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #1 July 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Abilify 30mg (1 time daily) • Depakote ER 500mg (1 time daily) • Acetaminophen 350mg (1 time daily) • Ativan 0.5 (3 times daily) • Abilify 20mg (1 time daily) • Lexapro 20mg (1 time daily) • Depo-provera Inject 0.5 (1 times every 4 weeks) August 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Depo-provera Inject 0.5 (1 time every 4 weeks) • Abilify 20mg (1 time daily) • Depakote ER 500mg (1 time daily) • Acetaminophen 350mg (1 time daily) • Ativan 0.5 (3 times daily)		

(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff	• Dival-proex sod ER 250mg (1 time daily) Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Abilify (1 time daily) – Blank 8/30 (8 AM) • Lexapro 20mg (1 time daily) – Blank 8/30 (8 AM) • Detrol LA 4mg (1 time daily) – Blank 8/30 (8 AM) • Acetaminophen 350mg (times daily) – Blank 8/30 (8 AM) • Ranitidine 150mg (2 times daily) – Blank 8/30 (8 AM) September 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Depo-Provera 400mg/ml VIA Inject 0.5ml (1 time every 4 weeks) • Abilify 20mg (1 time daily) • Depakote ER 500mg (1 time daily) • Acetaminophen 350mg (1 time daily) • Lorazepam 1mg (3 times daily) • Dival-proex sod ER 250mg (1 time daily) Individual #2 July 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:		

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.	• Valium 2mg (1 time daily) • Tenormin 25mg (1 time daily) • Trazodone 100mg (1 time daily) • Valium 5mg (1 time daily) • Budesonide 0.5mg/2ml (2 times daily) • Bentyl 20mg (3 times daily) August 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Valium 2mg (1 time daily) • Tenormin 25mg (1 time daily) • Trazodone 100mg (1 time daily) • Budesonide 0.5mg/2ml (2 times daily) • Bentyl 20mg (3 times daily) • Baclofen 10mg (3 times daily) • Valium 5mg (2 times daily) September 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Tenormin 25mg (1 time daily) • Trazodone 100mg (1 time daily) • Budesonide 0.5mg/2ml (2 times daily) • Valium 5mg (2 times daily)		

	• Baclofen 10mg (3 times daily) • Bentyl 20mg (3 times daily) Individual #4 July 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Zocar 5mg • Dimetapp 2 tablespoons • Erythrommycin ophthalmic ointment • Tears • Vitamin C 250mg • Vitamin E 100 • Patanol Medication Administration Records did not contain the dosage for the following medications: • Tears • Multivitamin • Patanol Medication Administration Records did not contain the frequency of medication to be given: • Zocar 5mg • Dimetapp 2 teaspoons • Erythrommycin ophthalmic ointment • Tears		

	• Multivitamin • Vitamin C 250mg • Vitamin E 100 • Patanol Medication Administration Record did not contain the specific time the medication should be given. MAR indicated time as “AM & PM”: • Zocar 5mg • Dimetapp 2 teaspoons • Erythrommycin ophthalmic ointment • Tears • Multivitamin • Vitamin C 250mg • Vitamin E 100 • Patanol August 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Zocar 5mg • Dimetapp 2 tablespoons • Erythrommycin ophthalmic ointment • Tears • Vitamin C 250mg		

	• Vitamin E 100 • Patanol Medication Administration Records did not contain the dosage for the following medications: • Dimetapp • Tears • Vitamin C • Vitamin E • Glucosamine • Multivitamin • Patanol Medication Administration Records did not contain the frequency of medication to be given: • Zocar 5mg • Dimetapp • Erythrommycin ophthalmic ointment • Tears • Vitamin C • Vitamin E • Patanol • Glucosamine • Multivitamin Medication Administration Record did not		

	contain the specific time the medication should be given. MAR indicated time as “AM & PM”: • Zocar 5mg • Dimetapp 2 teaspoons • Erythrommycin ophthalmic ointment • Tears • Vitamin C 250mg • Vitamin E 100 • Patanol • Glucosamine • Multivitamin September 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Dimetapp 2 tablespoons • Tears • Patanol • Erythrommycin ophthalmic ointment • Zocar 5mg • Multivitamin • Vitamin C • Vitamin E • Glucosamine 500mg		

	Medication Administration Records did not contain the dosage for the following medications: • Multivitamin (1 time daily) • Vitamin E • Vitamin C • Patanol Medication Administration Records did not contain the frequency of medication to be given: • Dimetapp 2 tablespoons • Tears • Patanol • Erythrommycin ophthalmic ointment • Zocar 5mg • Multivitamin • Vitamin C • Vitamin E • Glucosamine 500mg Medication Administration Record did not contain the specific time the medication should be given. MAR indicated time as “AM, PM”: • Dimetapp 2 tablespoons • Tears • Patanol • Erythrommycin ophthalmic ointment		

	• Zocar 5mg • Multivitamin • Vitamin C • Vitamin E • Glucosamine 500mg November 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Dimetapp 2 tablespoons (2 times daily) • Tears (4 times daily) • Patanol (1 time daily) • Erythrommycin ophthalmic ointment (1 time daily) • Glucosamine 500mg(1 time daily) • Multivitamin (1 time daily) • Vitamin C (1 time daily) • Vitamin E (1 time daily) Medication Administration Records did not contain the route of administration for the following medications: • Dimetapp 2 tablespoons (2 times daily) • Tears (4 times daily) • Glucosamine 500mg(1 time daily)		

	• Multivitamin (1 time daily) • Vitamin C (1 time daily) • Vitamin E (1 time daily) Individual #9 July 2010 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications: • Lexapro 20mg (1 time daily) • Gabapentin 250mg (2 times daily) • Divalproex 125mg (2 times daily) • Seroquel 200mg (1 time daily) • Trihexypen 0.4mg/ml (1 time daily) • Levetiracetam 5ml (1 time daily) • Levetriacetam 7.5ml (1 time daily) • Trazadone 100mg (1 time daily) August 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Valproic Acid 250mg/5ml (4 times daily) – Blank 7/29 (2PM & 8PM) September 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Valproic Acid 250mg/5ml (2 times daily) – Blank 9/28, 29 & 30 (8AM & 8PM)		

	• Lexapro 20mg (1 time daily) – Blank 9/28, 9/29 & 9/30 (8 AM) • Gabapentin syrup 250mg/5ml (2 times daily) – Blank 9/28, 29 & 30 (8AM & 8PM) • Seroquel 200mg (1 time daily) – Blank 9/29 (8 PM) • Trihexyphen 0.4mg (1 time daily) – Blank 9/28,29 & 30 (8 AM) • Trazodone 100mg (1 time daily) – Blank 9/28, 29 & 30 (8PM) • Omperazole 20mg (1 time daily) – Blank 9/28,29 & 30 (8 AM) • Docusate sodium 5ml (2 times daily) – Blank 9/28, 29 & 30 (8AM & 8PM) Individual #14 July 2010 Medication Administration Records did not contain the Name of the Individual for which the following medications are prescribed: • Loratadine 10mg (1 time daily) September 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Tegretol 100mg/5ml (2 times daily) – Blank 9/27 (8PM) & 9/28, 29 & 30 (4PM & 8PM) Individual #17 July 2010 Medication Administration Records did not contain the frequency of medication to be given: • Thioridazine 100mg		

	• Divalproex 500mg • Popranolol 80mg • Fluticasone 50mg • Benadryl 50mg August 2010 Medication Administration Records did not contain the frequency of medication to be given: • Thioridazine 100mg • Divalproex 500mg • Popranolol 80mg • Fluticasone 50mg • Benadryl 50mg September 2010 Medication Administration Records did not contain the frequency of medication to be given: • Thioridazine 100mg • Divalproex 500mg • Popranolol 80mg • Fluticasone 50mg • Benadryl 50mg Individual #18 September 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Fluoxetine HCL 20mg (1 time daily) Individual #19		

	July 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Loratadine 10mg (1 time daily) • Retin-A 0.025% (1 time daily) • Benzoyl Peroxide 10% (2 times daily) • Zyprexa 20mg (2 times daily) • Catapres 0.2mg (4times daily) Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Retin-A 0.025% (1 times daily) – Blank 7/27 (8 AM) August 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Loratadine 10mg (1 time daily) • Benzoyl Peroxide 10% (2 times daily) • Zyprexa 20mg (2 times daily) • Catapres 0.2mg (4times daily) • Retin-A 0.025% (1 time daily) September 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Zyprexa 20mg (2 times daily) • Benzoyl Peroxide 10% (2 times daily)		

	• Catapres 0.2mg (4times daily) • Retin-A 0.025% (1 time daily) Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Zyprexa (2 times daily) – Blank 9/26 (8 AM) • Retin-A 0.025% (1 time daily) – Blank 9/26 (8 PM) Individual #21 September 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Colace 100mg (2 times daily) Individual #22 July 2010 Medication Administration Records did not contain the strength of the medication which is to be given: • Dilantin 7ml (2 times daily) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Tums Solution 5ml (2 times daily) Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications: • Dilantin 7ml (2 times daily) • Diazepam 5mg (3 times daily) • Docusate Sodium 50mg/5ml (2 times daily)		

	• Bisacodyl 10mg (1 time every other day) • Tums solution 5ml (2 times daily) August 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Diazepam 5mg (3 times daily) – Blank 8/6, 9, 16, 20, 23 & 27 (9PM) • Dilantin 7ml (2 times daily) – Blank 8/7, 8, 14 & 15 (9AM & 7 PM) • Docusate Sodium 50mg/5ml (2 times daily) – Blank 8/6, 9, 13, 16, 20, 23 & 27 (9PM) & 8/7, 8, 14 & 15 (1PM & 9PM) Medication Administration Records did not contain the strength of the medication which is to be given: • Dilantin 7ml (2 times daily) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Maylox Solution 5ml (4 times daily) Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications: • Diazepam 5mg (3 times daily) • Dilantin 7ml (2 times daily) • Docusate Sodium 50mg/5ml (2 times daily) • Maylox Solution 5ml (4 times daily) • Bisacodyl 10mg (1 time every other day)		

	September 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Diazepam 5mg (3 times daily) – Blank 9/27 (9PM) • Docusate Sodium 50mg/5ml (2 times daily) – Blank 9/27 (9PM) Medication Administration Records did not contain the strength of the medication which is to be given: • Dilantin 7mg (2 times daily) • Ranitidine 5ml (2 times daily) Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications: • Diazepam 5mg (3 times daily) • Dilantin 7ml (2 times daily) • Docusate Sodium 50mg/5ml (2 times daily) • Maylox Solution 5ml (4 times daily) • Bisacodyl 10mg (1 time every other day) Individual #24 July 2010 Medication Administration Records did not contain the frequency of medication to be given: • Depakote 125mg • Clonidine 0.1mg August 2010		

	Medication Administration Records did not contain the frequency of medication to be given: • Depakote 125mg • Clonidine 0.1mg September 2010 Medication Administration Records did not contain the frequency of medication to be given: • Depakote 125mg • Clonidine 0.1mg Individual #25 July 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • EQ-Vegetable Laxative (2 times daily) – Blank 7/1, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (8 AM & 8PM) & 7/2, 3 & 12 (8PM) August 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • EQ-Vegetable Laxative (2 times daily) – Blank 8/1, 2, 4, 5, 6, 8, 9, 12, 13, 14, 16, 17, 18, 19 , 21, 22, 23, 26, 27, 28, 29, 30 & 31 (8AM & 8PM) & 8/3, 7, 10, 11, 15, 20, 24 & 25 (8PM) September 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • EQ-Vegetable Laxative (2 times daily) – Blank 9/1,3, 4, 5, 7, 8, 9, 10,11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (8AM & 8PM); 9/2, 6, 11 & 12 (8PM) November 2010		

	The following medications were found in the home during site visit on November 17, 2010. No Physician's Orders were found for the following medications: • Mupirocin 2% (2 times daily) • Fluocinonide Cream USP 0.05% (2 times daily) • Acyclorir 400mg (2 times daily) • D-3 400UI (1 time daily) • Multivitamin (1 time daily) Medication Administration Records did not contain the following medications: • Mupirocin 2% (2 times daily) • Fluocinonide Cream USP 0.05% (2 times daily) • Acyclorir 400mg (2 times daily) • D-3 400UI (1 time daily) • Multivitamin (1 time daily) As indicated by the Medication Administration Records the individual is to take Glyburide 5mg (1 time daily). According to the labeling medication container, Glyburide 5mg is to be taken 2 times daily. Medication Administration Record & Physician's Orders do not match labeling on medication bottle. Individual #27 November 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Fluoxetine 60mg (1 time daily) – Blank 11/3, 4, 5, 6 & 7 (6PM)		

	• Spectrum Fish Oil (1 time daily) – Blank 11/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 & 16 (10PM) • Bone-Up/Citracel 500mg (3 times daily) – Blank 11/8 (12PM &6PM) & 11/9, 10, 11, 12, 13 & 14 (7AM; 12PM &6PM)		

Tag # 1A09.1 Medication Delivery - PRN Medication	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 7 of 22 Individuals. Individual #1 August 2010 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 500mg – PRN – 8/17, 20 & 30 (given 1 time) Individual #2 July 2010 Medication Administration Records did not contain the circumstance for which the medication is to be used: • Robitussin A-C syrup/Guaifenesin (PRN) • Proair HFA 90mcg (PRN) • Docusate Sodium 100mg (PRN) August 2010 Medication Administration Records did not contain the circumstance for which the medication is to be used: • Robitussin A-C syrup/Guaifenesin (PRN) • Proair HFA 90mcg (PRN) • Docusate Sodium 100mg (PRN) September 2010 Medication Administration Records did not contain the circumstance for which the medication is to be used: • Robitussin A-C syrup/Guaifenesin (PRN)		

(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued	• Proair HFA 90mcg (PRN) • Docusate Sodium 100mg (PRN) Individual #9 August 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • ADAP/Codeine 10ml – PRN – 8/5, 6, 7, 8, 9, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 30 & 31 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • ADAP/Codeine 10ml – PRN – 8/5, 6, 7, 8, 9, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 30 & 31 (given 1 time) September 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Diazepam 5mg – PRN – 9/2, 7, 9, 14, 16, 21, 23 & 28 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Diazepam 5mg – PRN – 9/2, 7, 9, 14, 16, 21, 23 & 28 (given 1 time) Individual #18 July 2010 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 500mg – PRN – 7/1, 7, 19, 28, 30 & 31 (given 1 time) August 2010		

or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period. **Department of Health** **Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006** **F. PRN Medication** 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.	Medication Administration Record document did not contain an initial used to document administered or assisted delivery of each dose for the following medications: • Acetaminophen 500mg – PRN – 8/11 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 500mg – PRN – 8/23 (given 1 time) Individual #19 September 2010 Medication Administration Records did not contain the circumstance for which the medication is to be used: • Melatonin 1mg (PRN) Individual #24 July 21010 Medication Administration Records did not contain the circumstance for which the medication to be used: • Lorazapam 1mg (PRN) August 21010 Medication Administration Records did not contain the circumstance for which the medication to be used: • Lorazapam 1mg (PRN) September 21010 Medication Administration Records did not contain the circumstance for which the medication to be used: • Lorazapam 1mg (PRN) Individual # 25 July 2010 No Signs/Symptoms were noted on the		

4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention.	Medication Administration Record for the following PRN medication: • Alprazolam 0.5mg – PRN – 7/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) • Albuterol 2 puffs – PRN – 7/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) • Soma Carisoprodo 350mg – PRN - 7/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 times) • Rokiset 5/325mg – PRN – 7/2, 3, 4, 8, 9, 10 & 11 (given 1 time) & 7/1, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Alprazolam 0.5mg – PRN – 7/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) • Albuterol 2 puffs – PRN – 7/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) • Soma Carisoprodo 350mg – PRN - 7/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 times) • Rokiset 5/325mg – PRN – 7/2, 3, 4, 8, 9, 10 & 11 (given 1 time) & 7/1, 5, 12, 13, 14, 15, 16,		

(References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications). a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).	17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) August 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Alprazolam 0.5mg – PRN – 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) • Albuterol 2 puffs – PRN – 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) • Soma Carisoprodo 350mg – PRN – 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 times) • Rokiset 5/325mg – PRN – 8/21, 22, 25, 27 & 29 (given 1 time) & 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 23, 24, 26, 28, 30 & 31 (given 2 times) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Alprazolam 0.5mg – PRN – 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) • Albuterol 2 puffs – PRN – 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) • Soma Carisoprodo 350mg – PRN – 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18,		

	19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 times) • Rokiset 5/325mg – PRN – 8/21, 22, 25, 27 & 29 (given 1 time) & 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 23, 24, 26, 28, 30 & 31 (given 2 times) September 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Alprazolam 0.5mg – PRN – 9/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 3 times) • Albuterol 2 puffs – PRN - 9/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times) • Soma Carisoprodo 350mg – PRN - 9/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 1 times) • Rokiset 5/325mg – PRN – 9/7, 8, 11, 20 & 23 (given 2 times); 9/1, 2, 3, 4, 5, 6, 9,12, 13, 14, 15, 16, 17, 18, 18, 21, 22, 24, 25, 26, 27, 28, 29 & 30 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Alprazolam 0.5mg – PRN – 9/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 3 times) • Albuterol 2 puffs – PRN - 9/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21,		

	22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times) • Soma Carisoprodo 350mg – PRN - 9/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 1 times) • Rokiset 5/325mg – PRN – 9/7, 8, 11, 20 & 23 (given 2 times); 9/1, 2, 3, 4, 5, 6, 9,12, 13, 14, 15, 16, 17, 18, 18, 21, 22, 24, 25, 26, 27, 28, 29 & 30 November 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Rokiset 5/325mg – PRN – 11/1, 5 & 6 (given 2 times); 11/2, 9 (given 3 times) & 11/3, 4, 7, 8, 10, 11, 12, 13, 14, 15 & 16 (given 4 times) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Rokiset 5/325mg – PRN – 11/1, 5 & 6 (given 2 times); 11/2, 9 (given 3 times) & 11/3, 4, 7, 8, 10, 11, 12, 13, 14, 15 & 16 (given 4 times) The following medications were found in the home during site visit on November 17, 2010. No Physician's Orders were found for the following medications: • Nitroglycer 0.4mg – PRN Medication Administration Records did not contain the following medications: • Nitroglycer 0.4mg – PRN Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Nitroglycer 0.4mg – PRN		

	As indicated by the Medication Administration Records the individual is to take Soma Carisoprodo 350mg – PRN. According to the labeling medication container, Soma Carisoprodo 350mg is to be taken 2 times daily. Medication Administration Record & Physician's Orders do not match labeled medication container.		

Tag # 1A09.2 Medication Delivery - PRN Nurse Approval	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. **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	Based on record review, the Agency failed to maintain documentation of PRN usage as required by standard for 1 of 27 Individuals. Individual #25 November 2010 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Rokiset 5/325mg – PRN – 11/1, 5 & 6 (given 2 times); 11/2 & 9 (given 3 times) & 11/3, 4, 7, 8, 10, 11, 12, 13, 14, 15 & 16 (given 4 times)		

assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual. 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of			

consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications). a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.). **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.			

Tag # 1A11.1 (CoP) Transportation Training	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. **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 Staff Policy **Eff Date:** March 1, 2007	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 7 of 254 Direct Service Personnel. **No documented evidence was found of the following required training:** • Transportation (DSP #151, 248, 276 & 283) **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 #101 stated, "I don't remember." DSP #99 stated, "No." DSP #63 stated, "No."		

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 # 1A20 DSP Training Documents	Scope and Severity Rating: D		
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. B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 33 of 254 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #268 & 282) • Basic Health/Orientation (DSP #194, 120 & 229) • Person-Centered Planning (1-Day) (DSP #208, 272, 287, 290 & 293) • First Aid (DSP #43, 76, 168, 192 & 292) • CPR (DSP #75, 168 & 192) • Assisting With Medication Delivery (DSP #61, 73, 114, 118, 128, 131, 139, 142, 160, 181, 258, 272 & 277) • Rights & Advocacy (DSP #100, 189 & 194) • Level 1 Health (DSP #181) • Teaching & Support Strategies (DSP #189 & 194) • Positive Behavior Supports Strategies (DSP #79, 156, 194 & 197)		

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

Tag # 1A22 Staff Competence	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **F. Qualifications for Direct Service Personnel:** The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency: (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy	Based on interview, the Agency failed to ensure that training competencies were met for 8 of 37 Direct Service Personnel. **When DSP were asked if they received training on the Individual's Positive Behavioral Supports Plan and what the plan covered, the following was reported:** • DSP #288 stated, "Well no, she's going to come tomorrow and go over that. She has been with the Individual for 5 months." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan). (Individual #10) **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 #101 stated, "Not yet, I will on Thursday." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #13) **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 #63 stated, "No just given to read." As indicated by the Agency file, the Individual has Health Care Plans for Hypertension, Trouble walking, Exercise, Asthma & Constipation. (Individual #25) **When DSP were asked if they received training on the Individual's Crisis Plans and what the plan covered, the following was reported:** • DSP #288 stated, "Well no, she only came over		

Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and (5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support. (6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows: (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff.	once." As indicated by the Agency file, the Individual has Crisis Plans for diabetes, depression & seizures. (Individual #10) • DSP #99 stated, "No, not trained. I would have him sit down and breathe deep." According to Agency case file the individual has a Respiratory crisis plan. Individual (#18) • DSP #63 stated, "No just gave me to read." As indicated by the Agency file, the Individual has Crisis Plans for High Risk for Fractures. (Individual #10) • DSP #196 stated, "Monitor food intake, limit calorie intake, sunscreen for neck, and mobility & strengthening." As indicated by the Agency file, the Individual has crisis plans for Osteoporosis. (Individual #25) **When DSP were asked, what are the steps did they need to take before assisting an individual with PRN medication, the following was reported:** • DSP #254 stated, "I don't know." According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP) (Individual #3) • DSP #63 stated, "Make sure she gets it, chart on MAR, mark PRN." According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to		

	describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP) (Individual #25) **When DSP were asked, what are you to do if there is a medication error, the following was reported:** (i.e. missed, dropped, not filled, lost etc.) • DSP #62 stated, "I would throw a pill away that got on the floor and got dirty" (Individual #4) • DSP #69 stated, "I would throw it away, she only takes one medication." (Individual #5) • DSP #63 stated, "Throw it away, mark on MAR lost pill." (Individual #25) According to the Agency's Policy and Procedure: "Contaminated, outdated or recalled medications: 1. Contaminated medications (dropped medications that somehow got wet etc.) will be placed in a plastic bag for later destruction by the pharmacist. Place the individual's name, the medication name, the date and time and initial the bag. Place the bag in the individual's lock box to await destruction." **When DSP were asked if they knew what are the signs of high blood sugar for the Individual's Diabetes diagnosis, the following was reported:** • DSP #63 stated, "I don't know, call the doctor ask what to do". As indicated by the Agency file, the Individual has Crisis Plans for diabetes. (Individual #25)		

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: D		
NMAC 7.1.12.8 **REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED**: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.	Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 7 of 260 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** • #202 – Date of hire 3/10/2010. Completed 3/19/2010. • #247 – Date of hire 3/19/2010. Completed 3/19/2010. • #256 – Date of hire 3/08/2010. Completed 3/19/2010. • #285 – Date of hire 10/01/2007. Completed 10/25/2007. • #289 – Date of hire 9/06/2007. Completed 10/25/2007. • #290 – Date of hire 7/16/2007. Completed 7/31/2007. • #293 – Date of hire 9/06/2007. Completed 1/07/2008.		

E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1.IV. General Provider Requirements.** **D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.			

Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: E		
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 9 of 35 individuals. Individual #1 • Incident date 4/13/2010. Allegation was Abuse. Incident report was received 5/11/2010. Late Reporting. IMB Late & Failure Report indicated incident of Abuse was "Confirmed." Individual #28 • Incident date 12/28/2009. Allegation was Exploitation. Incident report was received 1/04/2010. Late Reporting. IMB Late & Failure Report indicated incident of Exploitation was "Confirmed." Individual #29 • Incident date 1/29/2010. Allegation was Exploitation. Incident report was received 1/29/2010. Late Reporting. IMB Late & Failure Report indicated incident of Exploitation was "Confirmed." Individual #30 • Incident date 6/15/2010. Allegation was Neglect. Incident report was received 6/16/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #31 • Incident date 6/22/2010. Allegation was Neglect. Incident report was received 6/22/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #32 • Incident date 8/10/2010. Allegation was		

	Exploitation. Incident report was received 8/11/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #33 • Incident date 8/17/2010. Allegation was Neglect. Incident report was received 8/17/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #34 • Incident date 8/07/2010. Allegation was Neglect. Incident report was received 8/17/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #35 • Incident date 8/09/2010. Allegation was Abuse. Incident report was received 8/19/2010. Late Reporting. IMB Late & Failure Report indicated incident of Abuse was "Confirmed."		

Tag # 1A28.1 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: D		
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 10 of 260 Agency Personnel. • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#95, 113, 133, 139, 183, 194, 236 & 272) **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 #213 stated, "I don't know." • DSP #196 stated, "Department of Health, call Mom, call agency." The DSP did not state APS.		

Tag # 1A28.2 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: E		
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **E. Consumer and Guardian Orientation Packet:** Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 7 of 27 individuals. • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#1, 3, 17, 18, 19, 21 & 25)		

Tag # 1A29 Complaints / Grievances - Acknowledgement	Scope and Severity Rating: 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 1 of 27 individuals. • Grievance/Complaint Procedure Acknowledgement (#18)		

Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: D		
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] **Long Term Services Division** **Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003** **IV. POLICY STATEMENT -** Human Rights Committees are required for residential service provider agencies. The purpose of these	Based on record review, the Agency failed to ensure the rights of Individuals was not restricted or limited for 5 of 27 Individuals. A review of Agency Individual files found no documentation of Positive Behavior Plans and/or Positive Behavior Crisis Plans, which contain restrictions being reviewed at least quarterly by the Human Rights Committee. (#17) A review of Agency Individual files indicated 5 of 5 Individuals required Human Rights Committee Approval for restrictions. No documentation was found regarding Human Rights Approval for the following: • Psychotropic Medications to control behaviors. No evidence found of Human Rights Committee approval. (Diazepam 5mg PRN, for Agitation) (Individual #9) • Physical Restraint (Physical Intervention per PBSP Crisis Plan) - (Individual #17) • Psychotropic Medications to control behaviors. No evidence found of Human Rights Committee approval. (Lorazapam 1mg PRN, for Behavior) (Individual #24) • Psychotropic Medications to control behaviors. No evidence found of Human Rights Committee approval. (Alprazolam 0.5mg PRN, for Anxiety) (Individual #25) • Physical Restraint (Physical Restraint, food restrictions per Prader Willi protocol) "Food restrictions, locking up food, and sharps, per Prader Willi protocol." No evidence found of Human Rights Committee approval. (Individual		

committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans. Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies: • Aversive Intervention Prohibitions • Psychotropic Medications Use • Behavioral Support Service Provision. A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up. **A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS** Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval. 2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly. 3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual's Individual Service Plan. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** **B. 1. e.** If the PRN medication is to be used in	#27)		

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

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: D		
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 3 of 27 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #17 • No Outcomes for Family Living Services. As indicated by NMAC 7.26.5.14 “Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.” **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • None found for 9/2010. Individual #15 • No Outcomes for Adult Habilitation Services. As indicated by NMAC 7.26.5.14 “Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.”		

Tag # 1A33 Board of Pharmacy - Med Storage	Scope and Severity Rating: A		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **E. Medication Storage:** 1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee. 2. Drugs to be taken by mouth will be separate from all other dosage forms. 3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature. 4. Separate compartments are required for each resident's medication. 5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day. 6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist. **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	Based on record review and observation, the Agency failed to ensure proper storage of medication for 3 of 24 individuals. Observation included: Individual #2 • Milk of Magnesium expired 5/2010. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Milk of Magnesium expired 7/2010. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Pepto Bismul expired 10/2008. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Pepto Bismul expired 1/2009. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Tums expired 7/2008. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Guaifenesin-codine syrup expired 9/2010. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Nasal Mist expired 11/2009. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.		

d. dose e. practitioner's name f. signature of person administering or assisting with the administration the dose g. balance of controlled substance remaining.	• Guafenesin expired 12/2008. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Acetaminophen 325mg, (1) bubble pack expired 12/2008. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Triple Abx ointment expired 4/2010. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Colace 100mg, (4) bubble packs expired 2/2009. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. Individual #10 • Ibuprofen 800mg expired 5/2010. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. Individual #25 • Klor-Con M10 - Is no longer in use as per documentation found and not kept in a separate place, as per regulation.		

Tag # 1A33.1 Board of Pharmacy - Lic	Scope and Severity Rating: A		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **6. Display of License and Inspection Reports** A. The following are required to be publicly displayed: ☐ Current Custodial Drug Permit from the NM Board of Pharmacy ☐ Current registration from the consultant pharmacist ☐ Current NM Board of Pharmacy Inspection Report	Based on observation, the Agency failed to provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 1 of 23 residences: Individual Residence: • Current NM Board of Pharmacy Inspection report (#16)		

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: D		
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 11 of 260 Agency Personnel. Review of personnel records found no evidence of the following: • Individual Specific Training (#58, 124, 180, 199, 209, 222, 226, 280, 282, 283 & 287)		

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Scope and Severity Rating: 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 1 of 12 individuals receiving Community Inclusion services. **Adult Habilitation Quarterly Reports** • Individual #19 - None found for 1/2010 - 3/2010		

Tag # 5I36 CA Reimbursement	Scope and Severity Rating: B		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XI. COMMUNITY ACCESS**	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 3 of 4 individuals. Individual #2 August 2010 • The Agency billed 80 units of Community Access from 8/8/2010 through 8/21/2010. Documentation received accounted for 64 units. September 2010 • The Agency billed 144 units of Community Access from 8/22/2010 through 9/18/2010. Documentation received accounted for 102 units. • The Agency billed 144 units of Community Access from 8/22/2010 through 9/18/2010. Documentation did not contain a signature/authenticated name of the staff providing the service on 9/3, 10 & 17 to justify billing. Individual #18 August 2010 • The Agency billed 70 units of Community Access from 7/25/2010 through 8/7/2010. Documentation received accounted for 56 units. September 2010 • The Agency billed 60 units of Community Access from 9/5/2010 through 9/18/2010. Documentation received accounted for 42 units. • The Agency billed 29 units of Community Access from 9/19/2010 through 10/2/2010. Documentation did not contain start and end time on 9/23 & 30 to justify billing.		

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.	Individual #27 September 2010 • The Agency billed 86 units of Community Access from 8/23/2010 through 9/4/2010. Documentation received accounted for 46 units.		

Tag # 5I44 AH Reimbursement	Scope and Severity Rating: C		
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. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XVI. REIMBURSEMENT** **A. Billable Unit**. A billable unit for Adult Habilitation	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 10 of 12 individuals. Individual #1 July 2010 • The Agency billed 217 units of Adult Habilitation from 7/11/2010 through 7/24/2010. Documentation did not contain start and end time on 7/13, 14, 19 & 20 to justify billing. August 2010 • The Agency billed 240 units of Adult Habilitation from 7/26/2010 through 8/6/2010. Documentation received accounted for 9 units. • The Agency billed 240 units of Adult Habilitation from 8/8/2010 through 8/21/2010. Documentation received accounted for 0 units. September 2010 • The Agency billed 196 units of Adult Habilitation from 8/22/2010 through 9/4/2010. Documentation received accounted for 76 units. Individual #3 July 2010 • The Agency billed 108 units of Adult Habilitation from 7/5/2010 through 7/10/2010. Documentation did not contain start and end time on 7/6, 7, 8, 9 & 10 to justify billing. • The Agency billed 202 units of Adult Habilitation from 7/11/2010 through 7/28/2010. Documentation did not contain start and end time on 7/13, 16, 17, 20, 21, 22, 23, 24 & 28 to justify billing. August 2010 • The Agency billed 110 units of 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	from 7/30/2010 through 8/7/2010. Documentation did not contain start and end time on 7/30, 31, 3, 4, 5 & 6 to justify billing. • The Agency billed 199 units of Adult Habilitation from 8/8/2010 through 8/21/2010. Documentation did not contain start and end time on 8/10, 11, 12, 14, 17, 9 & 20 to justify billing. September 2010 • The Agency billed 198 units of Adult Habilitation from 8/22/2010 through 9/4/2010. Documentation did not contain start and end time on 8/24, 25, 26, 27, 31, 2, 3 & 4 to justify billing. • The Agency billed 197 units of Adult Habilitation from 9/5/2010 through 9/18/2010. Documentation did not contain start and end time on 9/8, 9, 14, 15, 16 & 18 to justify billing. • The Agency billed 180 units of Adult Habilitation from 9/19/2010 through 10/2/2010. Documentation did not contain start and end time on 9/21, 22, 23, 25, 28 & 29 to justify billing. Individual #6 September 2010 • The Agency billed 122 units of Adult Habilitation from 8/22/2010 through 9/4/2010. Documentation received accounted for 92 units. • The Agency billed 109 units of SERVICE from 9/5/2010 through 9/18/2010. Documentation did not contain a signature/authenticated name of the staff providing the service on 9/17/2010 to justify billing. Individual #9 July 2010		

	• The Agency billed 80 units of Adult Habilitation from 6/29/2010 through 7/10/2010. Documentation did not contain the following on 7/2 & 7: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed 64 units of Adult Habilitation from 7/11/2010 through 7/17/2010. Documentation received accounted for 61 units. Individual #14 August 2010 • The Agency billed 240 units of Adult Habilitation from 7/25/2010 through 8/7/2010. Documentation received accounted for 232 units. Individual #15 August 2010 • The Agency billed 240 units of Adult Habilitation from 7/25/2010 through 8/7/2010. Documentation did not contain a signature/authenticated name of the staff providing the service on 7/27/2010 to justify billing. • The Agency billed 240 units of Adult Habilitation from 8/8/2010 through 8/21/2010. Documentation received accounted for 236 units. September 2010 • The Agency billed 240 units of Adult Habilitation from 8/22/2010 through 9/4/2010. Documentation received accounted for 234 units. Individual #16		

	August 2010 • The Agency billed 169 units of Adult Habilitation from 8/8/2010 through 8/21/2010. Documentation received accounted for 166 units. September 2010 • The Agency billed 168 units of Adult Habilitation from 8/22/2010 through 9/4/2010. Documentation received accounted for 131 units. Individual #18 July 2010 • The Agency billed 188 units of Adult Habilitation from 7/12/2010 through 7/24/2010. Documentation received accounted for 143 units. August 2010 • The Agency billed 167 units of Adult Habilitation from 7/25/2010 through 8/7/2010. Documentation received accounted for 71 units. • The Agency billed 174 units of Adult Habilitation from 8/8/2010 through 8/21/2010. Documentation received accounted for 120 units. September 2010 • The Agency billed 183 units of Adult Habilitation from 8/22/2010 through 9/4/2010. Documentation received accounted for 143 units. Individual #19 August 2010 • The Agency billed 240 units of Adult Habilitation from 7/25/2010 through 8/7/2010. Documentation did not contain start and end time on 7/29 & 30 to justify billing.		

	• The Agency billed 240 units of Adult Habilitation from 8/8/2010 through 8/21/2010. Documentation received accounted for 216 units. September 2010 • The Agency billed 107 units of Adult Habilitation from 8/22/2010 through 9/4/2010. Documentation received accounted for 100 units. • The Agency billed 216 units of Adult Habilitation from 9/5/2010 through 9/18/2010. Documentation received accounted for 163 units. Individual #21 August 2010 • The Agency billed 160 units of Adult Habilitation from 7/25/2010 through 8/7/2010. Documentation received accounted for 136 units. September 2010 • The Agency billed 160 units of Adult Habilitation from 9/5/2010 through 9/18/2010. Documentation received accounted for 0 units.		

Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES** **A**. **Support to Individuals in Family Living:** The Family Living Services Provider Agency shall provide and document: (5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include: (a) Review, advise, and prompt the implementation of the individual's ISP Action Plans, schedule of activities and appointments; and (b) Assist with service or support issues raised by the direct support provider or observed by supervisor, service coordinator or other IDT members. **B**. **Home Studies**. The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS** **D. Scope of DDSD Agreement**	Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 2 of 18 individuals. The following was not found, not current and/or incomplete: • Family Living (Annual Update) Home Study ◦ Individual #22 - Not Found. • Current Family Living Contract ◦ Individual #22 - Not Current. ◦ Individual #24 - Not Current.		

(4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite; **NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER** **ELIGIBLE PROVIDERS:** I. **Qualifications for community living service providers:** There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards. (1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.			

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty 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 5 of 27 individuals receiving Community Living Services. The following was not found, incomplete and/or not current: • **Vision Exam** ◦ Individual #17 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #23 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #24 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. • **Auditory Exam** ◦ Individual #27 - As indicated by the Annual physical PCP recommends auditory exam every two years, the Annual was completed on 12/2009. No evidence of an auditory exam was found. • **Blood Levels** ◦ Individual #10 - As indicated per Neurological evaluation recommends review for Valporic acid levels, lab work was ordered on 12/08/2009. Follow-up was to be completed every 6 months, last Valporic acid level checked 3/2010. No evidence of follow-up found. • **Review of Psychotropic Medication** ◦ Individual #17 - According to Pharmacologic Management visit Individual #17 is to have a medication review in 6-months. No evidence		

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).	was found for the following time frame to indicate they were completed (3/31/2010 – 9/2010).		

Tag # 6L14 Residential Case File	Scope and Severity Rating: E		
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	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 14 of 24 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 (#17 & 19) ° Did not contain Health Plan (Insurance) Information (#17, 25 & 26) ° Did not contain Individuals current address Information (#25) • Positive Behavioral Plan (#12) • Positive Behavioral Crisis Plan (#12) • Speech Therapy Plan (#9, 13 & 19) • Physical Therapy Plan (#2 & 14) • **Special Health Care Needs** ° Nutritional Plan (#25) • **Health Care Plans** ° Osteoarthritis (#4) ° Health Maintenance (#4) ° Psychotropic Medication use (#19) • **Crisis Plan** ° Allergies (#1, 13 & 14) ° Seizures (#25) • **Progress Notes/Daily Contacts Logs:**		

a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current 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...	◦ Individual #9 - None found for November 1 – 16, 2010 ◦ Individual #10 - None found for November 1 – 15, 2010 ◦ Individual #13 - None found for November 1 – 16, 2010 ◦ Individual #24 - None found for November 1 – 17, 2010 • **Data Collection/Data Tracking:** ◦ Individual #10 - None found for November 2010 ◦ Individual #13 - None found for November 2010 • **Progress Notes written by DSP and/or Nurses regarding Health Status:** ◦ Individual #10 - None found for November 2010 ◦ Individual #24 - None found for November 2010 • **Health Care Providers Written Orders** (#3, 10 & 25) • **Medication Administration Record (MAR)** ◦ Individual #13 - None found for July, August, and September 2010.		

Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services** (1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has: (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence; (b) General-purpose first aid kit; (c) When applicable due to an individual's health status, a blood borne pathogens kit; (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats; (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone; (f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift; (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or 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 13 of 23 Supported Living & Family Living residences. The following items were not found, not functioning or incomplete: **Supported Living Requirements:** • 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 (#16) **Family Living Requirements:** • General-purpose first aid kit (#25) • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#9 & 22) • 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 (#25 & 27) • Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#22 & 27) • 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 (#3, 5, 9, 10, 14, 17, 21, 22, 25, 26 & 27)		

	• 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 (#3, 5, 9, 14, 17, 24, 25, 26 & 27)		

Tag # 6L25.1 (CoP) Residential Reqts. (Physical Environment - Supported Living & Family Living)	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services** (2) Overall each residence shall maintain basic utilities, i.e., gas, power, water, telephone at the residence and shall maintain the physical environment in a safe and comfortable manner for the individuals. (3) Each individual shall have access to all household equipment and cleaning supplies unless precluded by his or her ISP. (4) Living and Dining Areas shall (a) Provide individuals free use of all space with due regard for privacy, personal possessions and individual interests; (b) Maintain areas for the usual functions of daily living, social, and leisure activities in a clean and sanitary condition; and (c) Provide environmental accommodations based on the unique needs of the individual. (5) Kitchen area shall: (a) Possess equipment, utensils, and supplies to properly store, prepare, and serve at least three (3) meals a day; (b) Arrangements will be made, in consultation with the IDT for environmental accommodations and assistive technology devices specific to the needs of the individual(s); and (c) Water temperature is required to be 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 1 of 18 Family Living residences. **Family Living Requirements:** During on-site visit (11/15/2010), surveyors observed the following: Surveyors on routine survey made a house visit to Individual #11 on November 15, 2010 at 3:30pm. During on-site visit, surveyors made these observations: The home in general was unkempt with spider webs throughout the home including bathroom, kitchen and individuals bedroom. Kitchen table had layer of film which was sticky to the touch. Stove had layer of grease and spider webs on side of stove to the wall. Bathroom had a black ring of soap scum, spider webs between shower wall and shower head and handle. Individuals bedroom was dusty and had spider webs throughout room An addition was added to home but remains unfinished, building supplies were observed in hallway. Electrical components were hanging from walls, although no exposed wires were observed. Residential concerns where brought to the attention of Executive Director of Agency.		

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 # 6L27 FL Reimbursement	Scope and Severity Rating: B		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES**	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 7 of 18 individuals. Individual #5 August 2010 • The Agency billed 1 unit of Family Living on 8/22/2010. Documentation did not contain a date to justify billing. • The Agency billed 1 unit of Family Living on 8/31/2010. Documentation did not contain a date to justify billing. Individual #9 July 2010 • The Agency billed 4 units of Family Living on 7/25/2010 through 7/28/2010. Review of documentation indicated services were provided concurrently with Hospitalization stay on 7/25/2010. August 2010 • The Agency billed 4 units of Family Living from 7/30/2010 through 8/2/2010. Review of documentation indicated services were provided concurrently with Hospitalization stay on 8/1 & 8/2. • The Agency billed 4 units of Family Living from 8/4/2010 through 8/7/2010. Review of documentation indicated services were provided concurrently with Hospitalization stay on 8/4/2010. • The Agency billed 10 units of Family Living from 8/16/2010 through 8/25/2010. Review of documentation indicated services were provided concurrently with Hospitalization stay on 8/16/2010.		

B. Reimbursement for Family Living Services (1) Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year. (2) Billable Activities shall include: (a) Direct support provided to an individual in the residence any portion of the day; (b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and (c) Any other activities provided in accordance with the Scope of Services. (3) Non-Billable Activities shall include: (a) The Family Living Services Provider Agency may not bill the for room and board; (b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and (c) Family Living services may not be billed for the same time period as Respite. (d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one midnight to the following midnight. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **Chapter 6 - COMMUNITY LIVING SERVICES** **III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES** **C. Service Limitations**. Family Living Services cannot be provided in conjunction with any other Community Living Service, Personal Support Service, Private Duty Nursing, or Nutritional Counseling. In addition, Family Living may not be delivered during the same time as respite; therefore,	Individual #11 August 2010 • The Agency billed 21 units of Family Living from 7/15/2010 through 8/4/2010 documentation on 8/1 & 2 did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed 7 units of Family Living from 8/5/2010 through 8/11/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed 7 units of Family Living from 8/12/2010 through 8/18/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed 7 units of Family Living from 8/19/2010 through 8/25/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. September 2010 • The Agency billed 14 units of Family Living from 8/26/2010 through 9/8/210. Documentation on these dates did not contain the following:		

a specified deduction to the daily rate for Family Living shall be made for each unit of respite received. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **DEFINITIONS SUBSTITUTE CARE** means the provision of family living services by an agency staff or subcontractor during a planned/scheduled or emergency absence of the direct service provider. **RESPITE** means a support service to allow the primary caregiver to take a break from care giving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.	◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed 7 units of Family Living from 9/9/2010 through 9/15/20. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed 7 units of Family Living from 9/16/2010 through 9/22/20. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed 14 units of Family Living from 9/23/2010 through 10/6/20. Documentation on 9/23, 24, 25, 26, 27, 28, 29 & 30 did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. Individual #14 September 2010 • The Agency billed 7 units of Family Living from 9/9/2010 through 9/15/20. Review of documentation indicated services were provided concurrently with Respite Service on 9/15/2010. • The Agency billed 7 units of Family Living from		

	9/16/2010 through 9/22/20. Review of documentation indicated services were provided concurrently with Respite Service on 9/16/2010. Individual #20 September 2010 • The Agency billed 21 units of Family Living from 8/19/2010 through 9/8/2010. Documentation received accounted for 19 units. No documentation was found for 8/30 & 31. Individual #21 August 2010 • The Agency billed 21 units of Family Living from 7/15/2010 through 8/4/2010. Review of documentation indicated services were provided concurrently with Sub-Care on 7/24, 25 & 26. September 2010 • The Agency billed 21 units of Family Living from 8/19/2010 through 9/8/2010. Review of documentation indicated services were provided concurrently with Sub-Care on 8/21, 22 & 23 and concurrently with Respite on 9/4, 5, 6 & 7. Individual #26 August 2010 • The Agency billed 7 units of Family Living from 8/12/2010 through 8/18/20. Review of documentation indicated services were provided concurrently with Respite Service and Community Access on 8/14 & 15. September 2010 • The Agency billed 14 units of Family Living from 8/26/2010 through 9/8/20. Review of documentation indicated services were provided concurrently with Respite Services and Community Access on 9/4, 5 & 6.		