

Katrina Hotrum
Deputy Secretary

Jessica Sutin
Deputy Secretary

Michael Mulligan
Acting Deputy Secretary

Karen Armitage, MD
Chief Medical Officer

Date: August 16, 2010

To: Connie Kalter, Executive Director
Provider: New Pathways, Inc.
Address: 1520 Tramway N.E. Ste. #220
State/Zip: Albuquerque, New Mexico 87112

E-mail Address: conniekalter@msn.com

Region: Northeast & Northwest
Original Survey Date: November 16 – 19, 2009
Verification Survey Date: July 19 – 21, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation)
Survey Type: Verification
Team Leader: Crystal Lopez-Beck, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Cynthia Nielsen, RN, MSN, ONC, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Florie Alire, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Anthony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Maurice Gonzales, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Valerie V. Valdez, MS, Healthcare Program Manager/Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Kalter,

The Division of Health Improvement/Quality Management Bureau has completed a verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI/DDSD regarding the Routine Survey on **November 16 - 19, 2009**.

These findings will be reviewed by the DOH – Internal Review Committee during an upcoming review meeting. The findings are attached.

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

Sincerely,

Crystal Lopez-Beck, BA

Crystal Lopez-Beck, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement/QMB

Sincerely,

Valerie V. Valdez, MS

Valerie V. Valdez, MS
Healthcare Program Manager
Division of Health Improvement/QMB



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

David Rodriguez, Division Director • Division of Health Improvement

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

Survey Process Employed:

Entrance Conference Date: July 19, 2010

Present: **New Pathways, Inc.**
Connie Kalter, Executive Director
Jennifer Dillard, RN/Health Care Coordinator
Renee Duncan, SL Supervisor

DOH/DHI/QMB

Crystal Lopez-Beck, BA, Team Lead/Healthcare Surveyor
Nadine Romero, LBSW, Healthcare Surveyor
Cynthia Nielsen, RN, MSN, ONC, Healthcare Surveyor
Florie Alire, RN, Healthcare Surveyor
Anthony Fragua, BFA, Healthcare Surveyor
Maurice Gonzales, BS, Healthcare Surveyor
Marti Madrid, LBSW, Healthcare Surveyor

Exit Conference Date: July 21, 2010

Present: **New Pathways, Inc.**
Connie Kalter, Executive Director
Jennifer Dillard, RN/Health Care Coordinator
Renee Duncan, SL Supervisor

DOH/DHI/QMB

Crystal Lopez-Beck, BA, Team Lead/Healthcare Surveyor
Nadine Romero, LBSW, Healthcare Surveyor
Cynthia Nielsen, RN, MSN, ONC, Healthcare Surveyor
Florie Alire, RN, Healthcare Surveyor
Anthony Fragua, BFA, Healthcare Surveyor
Maurice Gonzales, BS, Healthcare Surveyor
Marti Madrid, LBSW, Healthcare Surveyor

Homes Visited Number: 3

Administrative Locations Visited Number: 1

Total Sample Size Number: 3
0 - Jackson Class Members
3 - Non-Jackson Class Members
3 - Family Living

Records Reviewed (Persons Served) Number: 3

Administrative Files Reviewed

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

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

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

Key to Scope scale:

Isolated:

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

Pattern:

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

Widespread:

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

Key to Findings:

“Substantial Compliance with Conditions of Participation”

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

“Non-Compliance with Conditions of Participation”

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

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

“Sub-Standard Compliance with Conditions of Participation”:

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

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

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

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

Introduction:

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

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

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

The following limitations apply to the IRF process:

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

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

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

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

Agency: New Pathways, Inc. - Northwest & Northeast Region
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation)
Monitoring Type: Verification Survey
Original Survey Date: November 16 – 19, 2009
Verification Survey Date: July 19 - 21, 2010

Statute	November 16 - 19, 2009 Deficiencies	July 19 - 21, 2010 Verification Survey - New and Repeat Deficiencies
Tag # 1A03 CQI System	Scope and Severity Rating: C	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS</p> <p>I. Continuous Quality Management System: Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to:</p> <ol style="list-style-type: none"> (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents 	<p>Based on record review, the Agency failed to develop and implement a Continuous Quality Management System.</p> <p>Review of the Agency's Continuous Quality Improvement Plan provided during the on-site survey did not contain the components required by Standards.</p> <p>The Agency's General CQI Plan did not contain details on how the following components will be achieved:</p> <ol style="list-style-type: none"> (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction <p>When asked about the Agency's General CQI</p>	<p>Complete</p>

<p>leading to adverse health events;</p> <p>(5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;</p> <p>(6) Quality and completeness documentation; and</p> <p>(7) Trends in individual and guardian satisfaction.</p> <p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>E. Quality Improvement System for Community Based Service Providers: The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system:</p> <p>(1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;</p> <p>(2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;</p> <p>(4) community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.</p>	<p>Plan the following was reported:</p> <p>#72 stated, "Our process is not 100%. It depends on the problems at the time... We meet quarterly on managing outcomes to review address and modify our QA process. But sometimes we don't follow up on the old one."</p> <p>The Agency's Incident Management CQI Plan did not contain the following components:</p> <p>(1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;</p> <p>(4) community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.</p> <p>When asked if the Agency had an Incident Management Quality Improvement System, which included, a process for reviewing alleged, complaints & incident; documentation of internal investigations of alleged violations; reasonable steps taken to prevent further incident and documentation of corrective active, the following was reported:</p> <p>#72 stated, "As a whole agency, we look at trends informally. We do not keep minutes and do not have a formal committee."</p>	
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Tag # 1A05 (CoP) General Requirements	Scope and Severity Rating: F	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>A. General Requirements:</p> <p>(2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDS policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.</p>	<p>Based on record review, the Agency failed to review and update its written policies and procedures every three years or as needed.</p> <p>The following polices and procedures provided during the on-site survey (November 16, 2009) showed no evidence of being reviewed every three years or being updated as needed:</p> <ul style="list-style-type: none"> • “Policy Number: P-13 – Policy and Procedures Organization” - Last reviewed and/or revised 12/2001. • “Policy Number: P-38 – Authorization of money for the consumer and on behalf of New Pathways” - Last reviewed and/or revised 08/2003. • “Policy Number: P-38 A – Reimbursement of Consumers’ and New Pathways Monies” - Last reviewed and/or revised 08/2003. • “Policy Number: P-46 – Complaint Procedure” - Last reviewed and/or revised 10/2001. • “Policy Number: P-67 – On call staff coverage and emergency on call responsibilities” - Last reviewed and/or revised 10/2001. • “Policy Number: P-79 – Pharmacy Review/Services” - Last reviewed and/or revised 10/2001. • “Policy Number: P-82 – Monthly Medication Review” - Last reviewed and/or revised 07/2002. • “Policy Number: P-89 – Allergies, Drug Reaction, Medications Errors” - Last reviewed and/or revised 10/2001. • “Policy Number: P-90 – Assisting with Medication” - Last reviewed and/or revised 10/2001. 	<p>Resolved as a result of the Informal Reconsideration of Findings process.</p>

- “Policy Number: P-121 – General Evacuation” - Last reviewed and/or revised 10/2001.
- “Policy Number: P-136 – Incident Management System/Reportable Incident” - Last reviewed and/or revised 09/2001.
- “Policy Number: P-137 – Incident Management System for Reporting Deaths” - Last reviewed and/or revised 10/2001.
- “Policy Number: P-144 – Day Programs/Activities”- Last reviewed and/or revised 09/2001.
- “Policy Number: P-145 – Consumer Grievance and/or Complaints” - Last reviewed and/or revised 10/2001.
- “Policy Number: P-152 – Accident Reporting” - Last reviewed and/or revised 09/2001.
- “Policy Number: P-153 – Transportation and Safety” - Last reviewed and/or revised 11/2002.
- “Policy Number: P-154 – Follow up to Prevent Future Accidents” - Last reviewed and/or revised 05/2003.
- “Policy Number: P-155 – Training on how to Transport Individuals” - Last reviewed and/or revised 05/2003.
- “Policy Number: P-170 – Authorization for money for the Consumer and on behalf of New Pathways” - Last reviewed and/or revised 08/2003.
- “Policy Number: P-171 – Reimbursement of Consumers and New Pathways Monies” - Last reviewed and/or revised 08/2003.
- “Policy Number: P-174 – Financial accounting of

	<p>expenditures on behalf of a Consumer” - Last reviewed and/or revised 08/2003.</p> <ul style="list-style-type: none">• “Policy Number: P-175 – New pathways financial accounting of expenditures” - Last reviewed and/or revised 08/2003.• “Policy Number: P-208 – Allergies, Drug Reaction, Medication Errors” - Last reviewed and/or revised 10/2001.• “Policy Number: P-212 – Community Based Day Habilitation - Last reviewed and/or revised 06/2002.	
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Tag # 1A08 Agency Case File	Scope and Severity Rating: B	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency...</p> <p>Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</p> <p>(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;</p> <p>(2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);</p> <p>(3) Progress notes and other service delivery documentation;</p> <p>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</p> <p>(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...</p>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 10 of 15 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ Did not contain Pharmacy Information (#8) ◦ Did not contain current Case Manager Information (#9) • Addendum A (#12) • Speech Therapy Plan (#10 & 11) • Occupational Therapy Plan (#2 & 7) • Physical Therapy Plan (#3, 5, 9, 10 & 13) 	<p>Complete</p>

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: F	Scope and Severity Rating: F
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <ol style="list-style-type: none"> The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; Prescribed dosage, frequency and method/route of administration, times and dates of administration; Initials of the individual administering or assisting with the medication; Explanation of any medication irregularity; Documentation of any allergic reaction or adverse medication effect; and For PRN medication, an explanation for the 	<p>Medication Administration Records (MAR) were reviewed for the months of July, August & September, 2009.</p> <p>Based on record review, 10 of 14 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #2 July 2009 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Loratadine 10mg (1 time daily) • Strattera XR 60mg (1 time daily) • Levothyroid .050mg (1 time daily) • Divalproex 500mg (2 times daily) • Topomax 50mg (2 times daily) • Oxcarbazepine 150mg (2 times daily) • Risperdal 2mg (1 time daily) • Mirtazpine 15mg (1 time daily) • Divalproex DR 500 mg (2 times daily) <p>August 2009 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Loratadine 10mg (1 time daily) 	<p>New & Repeat Findings:</p> <p>Medication Administration Records (MAR) were reviewed for the months of April & May 2010.</p> <p>Based on record review, 3 of 3 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #2 April 2010</p> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxine 75mcg (1 time daily) • Loratadine 10mg (1 time daily) • Strattera XR 60mg (1 time daily) • Omega 3 – Fish Oil 1000mg (1 time daily) • Topirimate 100mg (2 times daily) • Risperdal 2 mg (1 time daily) • Depakote ER 500mg (1 time daily) • Mirtazapine 15mg (1 time daily) <p>May 2010 Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxine 75mcg (1 time daily) • Loratadine 10mg (1 time daily)

<p>use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. 	<ul style="list-style-type: none"> • Strattera XR 60mg (1 time daily) • Levothyroid .050mg (1 time daily) • Divalproex 500mg (2 times daily) • Topomax 50mg (2 times daily) • Oxcarbazepine 150mg (2 times daily) • Risperdal 2mg (1 time daily) • Mirtazpine 15mg (1 time daily) • Divalproex DR 500 mg (2 times daily) <p>September 2009 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Loratadine 10mg (1 time daily) • Strattera XR 60mg (1 time daily) • Levothyroid .050mg (1 time daily) • Divalproex 500mg (2 times daily) • Topomax 50mg (2 times daily) • Oxcarbazepine 150mg (2 times daily) • Risperdal 2mg (1 time daily) • Mirtazpine 15mg (1 time daily) • Divalproex DR 500 mg (2 times daily) 	<ul style="list-style-type: none"> • Strattera XR 60mg (1 time daily) • Omega 3 – Fish Oil 1000mg (1 time daily) • Topirimate 100mg (2 times daily) • Risperdal 2 mg (1 time daily) • Depakote ER 500mg (1 time daily) • Mirtazapine 15mg (1 time daily) <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Risperdal 2 mg (1 time daily) – Blank 5/13 • Depakote ER 500mg (1 time daily) – Blank 5/13 • Mirtazapine 15mg (1 time daily) – Blank 5/13 <p>Individual #9 April 2010</p> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Topamax 100mg (2 times daily) – Blank 4/29 (PM). <p>Individual #11 April 2010</p> <p>Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> • Fish Oil OTC (2 times daily) • Colace 100mg (1 time daily) • Alendronate 35mg (1 time weekly)
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<p>Model Custodial Procedure Manual D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> ➤ symptoms that indicate the use of the medication, ➤ exact dosage to be used, and ➤ the exact amount to be used in a 24 hour period. 	<p>Individual # 4 July 2009 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Lantus 22 Units (1 time daily) • Ditropan 10mg (1 time daily) • Byetta 10mg (2 times daily) • Paxil 30mg (1 time daily) • Bactrim 100mg (1 time daily) • Flonase 50MCG (1 time daily) • Fosamax (1 time weekly) <p>August 2009 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Lantus 22 Units (1 time daily) • Ditropan 10mg (1 time daily) • Byetta 10mg (2 times daily) • Paxil 30mg (1 time daily) • Bactrim 100mg (1 time daily) • Flonase 50MCG (1 time daily) • Fosamax (1 time weekly) <p>September 2009</p>	<ul style="list-style-type: none"> • Tricor 48mg (1 time daily) <p>As indicated by the Medication Administration Records the individual takes Folic Acid 800mcg (1 time daily). According to the Physician's Orders, Folic Acid 1mg (1 time daily) is to be taken Medication Administration Record & Physician's Orders do not match.</p> <p>May 2010</p> <p>Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> • Fish Oil OTC (2 times daily) • Colace 100mg (1 time daily) • Alendronate 35mg (1 time weekly) • Tricor 48mg (1 time daily) <p>As indicated by the Medication Administration Records the individual takes Folic Acid 800mcg (1 time daily). According to the Physician's Orders, Folic Acid 1mg (1 time daily) is to be taken Medication Administration Record & Physician's Orders do not match.</p>
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	<p>Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Lantus 22 Units (1 time daily) • Ditropan 10mg (1 time daily) • Byetta 10mg (2 times daily) • Paxil 30mg (1 time daily) • Bactrim 100mg (1 time daily) • Flonase 50MCG (1 time daily) • Fosamax (1 time weekly) <p>Individual #5 July 2009</p> <p>Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Depakote 500mg (2 times daily) • Risperdal 2mg (2 times daily) • Tricor 48mg (1 time daily) • Simvastatin 40mg (1 time daily) • Levothyroxine .75mg (1 time daily) • Digestive Enzymes 500mg (3 times daily) • WelBet Glucose Packet (1 time daily) <p>August 2009 Medication Administration Record document did</p>	
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	<p>not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Depakote 500mg (2 times daily) • Risperdal 2mg (2 times daily) • Tricor 48mg (1 time daily) • Simvastatin 40mg (1 time daily) • Levothyroxine .75mg (1 time daily) • Digestive Enzymes 500mg (3 times daily) • WelBet Glucose Packet (1 time daily) <p>September 2009 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Depakote 500mg (2 times daily) • Risperdal 2mg (2 times daily) • Tricor 48mg (1 time daily) • Simvastatin 40mg (1 time daily) • Levothyroxine .75mg (1 time daily) • Digestive Enzymes 500mg (3 times daily) • WelBet Glucose Packet (1 time daily) <p>Individual #6 July 2009 Medication Administration Records did not contain the dosage for the following medications:</p>	
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	<ul style="list-style-type: none"> • Calcium Vitamin D <p>August 2009 Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Calcium Vitamin D <p>September 2009 Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Calcium Vitamin D <p>Individual #7 July 2009 Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Zyprexa 5mg • Acetophlous (2 times daily) <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Acetophlous (2 times daily) <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Zyprexa 5mg <p>Medication Administration Records did not contain the dosage of medication to be given:</p> <ul style="list-style-type: none"> • Acetophlous (2 times daily) <p>August 2009 Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Zyprexa 5mg • Acetophlous (2 times daily) 	
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	<p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Acetophlous (2 times daily) • Gentamicin 3mg (4 times daily) <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Zyprexa 5mg <p>Medication Administration Records did not contain the dosage of medication to be given:</p> <ul style="list-style-type: none"> • Acetophlous (2 times daily) <p>September 2009</p> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Zyprexa 5mg • Acetophlous (2 times daily) • Omeprazole 4mg (1 time daily) <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Zyprexa 5mg <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Acetophlous (2 times daily) <p>Medication Administration Records did not contain the dosage of medication to be given:</p> <ul style="list-style-type: none"> • Acetophlous (2 times daily) <p>Individual #9 July 2009</p> <p>Medication Administration Record document did not contain a signature page that designates the</p>	
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	<p>full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Folic Acid 1mg (1 time daily) • Enulose 10gm (2 – 3 times daily) • Topomax 100mg (2 times daily) • Clonazepam 1mg (2 times daily) • Triliptal 600mg (2 times daily) • Ranitidine 15mg (2 times daily) • Reglan 5mg (4 times daily) • Warfarin 5mg (1 time daily) • Potassium Chloride 10% (2 times daily) <p>Medication Administration Record did not contain the exact time medications were given. Medication Administration Record indicated “AM, PM, or Bedtime” for the following medication:</p> <ul style="list-style-type: none"> • Folic Acid 1mg (1 time daily) • Enulose 10gm (2 – 3 times daily) • Topomax 100mg (2 times daily) • Clonazepam 1mg (2 times daily) • Triliptal 600mg (2 times daily) • Ranitidine 15mg (2 times daily) • Reglan 5mg (4 times daily) • Warfarin 5mg (1 time daily) 	
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	<ul style="list-style-type: none"> • Potassium Chloride 10% (2 times daily) <p>August 2009 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Folic Acid 1mg (1 time daily) • Enulose 10gm (2 – 3 times daily) • Topomax 100mg (2 times daily) • Clonazepam 1mg (2 times daily) • Trilipital 600mg (2 times daily) • Ranitidine 15mg (2 times daily) • Reglan 5mg (4 times daily) • Warfarin 5mg (1 time daily) • Potassium Chloride 10% (2 times daily) <p>Medication Administration Record did not contain the exact time medications were given. Medication Administration Record indicated “AM, PM, or Bedtime” for the following medication:</p> <ul style="list-style-type: none"> • Folic Acid 1mg (1 time daily) • Enulose 10gm (2 – 3 times daily) • Topomax 100mg (2 times daily) • Clonazepam 1mg (2 times daily) • Trilipital 600mg (2 times daily) • Ranitidine 15mg (2 times daily) 	
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- Reglan 5mg (4 times daily)
- Warfarin 5mg (1 time daily)
- Potassium Chloride 10% (2 times daily)

September 2009

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:

- Folic Acid 1mg (1 time daily)
- Enulose 10gm (2 – 3 times daily)
- Topomax 100mg (2 times daily)
- Clonazepam 1mg (2 times daily)
- Trilipal 600mg (2 times daily)
- Ranitidine 15mg (2 times daily)
- Reglan 5mg (4 times daily)
- Warfarin 5mg (1 time daily)
- Potassium Chloride 10% (2 times daily)

Medication Administration Record did not contain the exact time medications were given. Medication Administration Record indicated “AM, PM, or Bedtime” for the following medication:

- Folic Acid 1mg (1 time daily)
- Enulose 10gm (2 – 3 times daily)
- Topomax 100mg (2 times daily)

	<ul style="list-style-type: none"> • Clonazepam 1mg (2 times daily) • Trilipal 600mg (2 times daily) • Ranitidine 15mg (2 times daily) • Reglan 5mg (4 times daily) • Warfarin 5mg (1 time daily) • Potassium Chloride 10% (2 times daily) <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Folic Acid 1mg (1 time daily) <p>Individual #10 September 2009</p> <p>Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Lexapro 20mg (1 time daily) • Risperdal 2mg (2 times daily) • Trazodone 100mg (1 time daily) <p>Individual #11 September 2009</p> <p>Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Olanzapine 7.5mg (1 time daily) • Folic Acid 800mg (1 time daily) 	
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	<ul style="list-style-type: none"> • Calcium 500mg (1 time daily) • Multivitamin (1 time daily) • Vitamin C 500mg (1 time daily) • Prozac 60mg (1 time daily) • Simvastatin 80mg (1 time daily) • Tegretol 200mg (2 times daily) <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Colace (2 times daily) <ul style="list-style-type: none"> • Fish Oil (2 times daily) <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Colace (2 times daily) • Fish Oil (2 times daily) <p>Individual #13 July 2009</p> <p>Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Miralax 1capful (1 time every other day) • Phenobarbital 20mg (1 time daily) • Tegretol 100mg (3 times daily) <p>August 2009</p> <p>Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to</p>	
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	<p>document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Miralax 1capful (1 time every other day) • Phenobarbitol 20mg (1 time daily) • Tegretol 100mg (3 times daily) <p>September 2009 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Miralax 1capful (1 time every other day) • Phenobarbitol 20mg (1 time daily) • Tegretol 100mg (3 times daily) <p>Individual #15 July 2009 During on-site survey Medication Administration Records were requested for month of July. As of December 3, 2009, Medication Administration Records had not been provided.</p> <p>During on-site survey (November 16 - 19, 2009) Physician Orders were requested. As of (12/03/2009), Physician Orders had not been provided.</p> <p>August 2009 During on-site survey Medication Administration Records were requested for month of August. As of December 3, 2009, Medication Administration Records had not been provided.</p> <p>During on-site survey (November 16 - 19, 2009) Physician Orders were requested. As of (12/03/2009), Physician Orders had not been provided.</p>	
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	<p>September 2009 During on-site survey Medication Administration Records were requested for month of September. As of December 3, 2009, Medication Administration Records had not been provided.</p> <p>During on-site survey (November 16 - 19, 2009) Physician Orders were requested. As of (12/03/2009), Physician Orders had not been provided.</p>	
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Tag # 1A09 Medication Delivery - PRN Medication	Scope and Severity Rating: E	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: ...These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDS Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDS Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <ul style="list-style-type: none"> (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. 	<p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 4 of 14 Individuals.</p> <p>Individual #6 July 2009 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Tylenol 325mg – PRN – July 6, 8 & 9. (given 1 time daily)</p> <p>Individual # 7 July 2009 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Tylenol 325mg – PRN – July 6, 8 & 9. (given 1 time daily)</p> <p>August 2009 Medication Administration Record did not contain dosage for the following medications: • Pepto Bismol (PRN) • Imodium 2tsp (PRN) • Mylanta (PRN) • Loratadine (PRN) • Flunisolide (PRN)</p> <p>Individual #8 July 2009 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Tramadol – PRN – July 22, 28 & 29. (given 1</p>	<p>Complete</p>

<p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. <p>Model Custodial Procedure Manual - D. Administration of Drugs</p> <p>Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have</p>	<p>time daily)</p> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Ondansetron 8mg– PRN • Metolorpramine 10mg (PRN) <p>August 2009</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Tramadol – PRN – July 22, 28 & 29. (given 1 time daily) <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Ondansetron 8mg– PRN • Metolorpramine 10mg (PRN) <p>Individual #12</p> <p>September 2009</p> <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Laxative (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Laxative (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Laxative– PRN – September 27. (given 1 time daily) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p>	
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complete detail instructions regarding the administering of the medication. This shall include:

- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006 - F. PRN Medication

3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.

4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy).

H. Agency Nurse Monitoring

1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the

• Laxative – PRN – September 27. (given 1 time daily)

individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication.

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

C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).

a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.

4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).

Tag # 1A09 Medication Delivery - PRN Nurse Approval	Scope and Severity Rating: D	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006</p> <p>F. PRN Medication</p> <p>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</p>	<p>Based on record review, the Agency failed to maintain documentation of PRN usage as required by standard for 1 of 14 Individuals.</p> <p>Individual # 7 July 2009 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:</p> <ul style="list-style-type: none"> • Imodium 2tsp (PRN) – July 29 & 30. (given 2 times daily) <p>August 2009 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:</p> <ul style="list-style-type: none"> • Lorazepam 1mg (PRN) – August 13, 14 & 21. (given 1 time daily) • Pepto Bismol (PRN) – August 1 (given 2 times daily) • Imodium 2tsp (PRN) – August 5, 6, 7, 8, 29 & 30 (given 1 time daily) • Mylanta (PRN) - August 13 (given 1 time daily) • Loratadine (PRN) – August 13, 14, 15, 18 & 31 (given 1 time daily) • Flunisolide (PRN) - August 13, 14, 18, 19 & 20 (given 1 time daily) <p>September 2009 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:</p>	<p>Complete</p>

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

- Lorazepam 1mg (PRN) – September 11, 12, 13 & 22. (given 1 time daily)
- Imodium 2tsp (PRN) – September 9, 10 & 11. (given 1 time daily)

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 (CoP) Transportation Training	Scope and Severity Rating: D	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: ...These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>G. Transportation: Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community....</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Training Requirements for Direct Service Agency Staff Policy Eff Date: March 1, 2007 - II. POLICY STATEMENTS:</p> <p>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:</p> <ol style="list-style-type: none"> 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) 	<p>Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 5 of 53 Direct Service Personnel.</p> <p>No documented evidence was found of the following required training:</p> <ul style="list-style-type: none"> • Transportation (DSP #30 & 47) <p>When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported:</p> <ul style="list-style-type: none"> • DSP #49 stated "No, no training." • DSP #50 stated "No." • DSP #67 stated, "No, no driving class." 	<p>Complete</p>

Tag # 1A12 Reimbursement/Billable Units	Scope and Severity Rating: C	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</p> <p>B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <ol style="list-style-type: none"> (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</p> <p>Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed, which contained the required information for 9 of 12 individuals.</p> <p>Individual #1 July 2009</p> <ul style="list-style-type: none"> • The Agency billed 16 units of Family Living from 7/01/2009 through 7/31/2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. <p>August 2009</p> <ul style="list-style-type: none"> • The Agency billed 16 units of Family Living from 8/01/2009 through 8/31/2009. Documentation did not contain start and end time to justify billing. <p>Individual #2 July 2009</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 7/01/2009 through 7/31/2009. Documentation did not contain start and end time to justify billing. <p>August 2009</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 8/01/2009 through 8/31/2009. Documentation did not contain start and end time to justify billing. <p>September 2009</p> <ul style="list-style-type: none"> • The Agency billed 15 units of Family Living from 9/01/2009 through 9/15/2009. Documentation did not contain start and end time to justify billing. <p>Individual #3 July 2009</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 7/01/2009 through 7/31/2009. Documentation did not contain start and end time to justify billing. <p>August 2009</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 	<p>Complete</p>

	<p>8/01/2009 through 8/31/2009. Documentation did not contain start and end time to justify billing.</p> <p>Individual #7 July 2009</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 7/01/2009 through 7/31/2009. Documentation did not contain start and end time to justify billing for 7/3, 4, 11, 12, 18, 19, 25 & 26, 2009. <p>August 2009</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 8/01/2009 through 8/31/2009. Documentation did not contain start and end time to justify billing for 8/1, 2, 7, 8, 9, 15, 16, 22, 23, 24, 29 & 30, 2009. <p>September 2009</p> <ul style="list-style-type: none"> • The Agency billed 15 units of Family Living from 9/01/2009 through 9/15/2009. Documentation did not contain start and end time to justify billing for 9/1, 5, 6, 7, 12 & 13, 2009. <p>Individual #10 July 2009</p> <ul style="list-style-type: none"> • The Agency billed 16 units of Family Living from 7/01/2009 through 7/31/2009. Documentation did not contain start and end time to justify billing. <p>August 2009</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 8/01/2009 through 8/31/2009. Documentation did not contain start and end time to justify billing. <p>September 2009</p> <ul style="list-style-type: none"> • The Agency billed 15 units of Family Living from 9/01/2009 through 9/15/2009. Documentation did not contain start and end time to justify billing. <p>Individual #12 July 2009</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 7/01/2009 through 7/31/2009. Documentation did 	
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	<p>not contain start and end time to justify billing.</p> <p>August 2009</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 8/01/2009 through 8/31/2009. Documentation did not contain start and end time to justify billing. <p>September 2009</p> <ul style="list-style-type: none"> • The Agency billed 15 units of Family Living from 9/01/2009 through 9/15/2009. Documentation did not contain start and end time to justify billing. <p>Individual #13</p> <p>July 2009</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 7/01/2009 through 7/31/2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. <p>August 2009</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 8/01/2009 through 8/31/2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. <p>September 2009</p> <ul style="list-style-type: none"> • The Agency billed 15 units of Family Living from 9/01/2009 through 9/15/2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. <p>Individual #14</p> <p>July 2009</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 7/01/2009 through 7/31/2009. Documentation did not contain start and end time to justify billing. <p>Individual #15</p> <p>July 2009</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 7/01/2009 through 7/31/2009. Documentation did not contain start and end time to justify billing. 	
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August 2009

- The Agency billed 15 units of Family Living from 8/01/2009 through 8/15/2009. Documentation did not contain start and end time to justify billing.

Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: E	Scope and Severity Rating: D
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>(1) Documentation of nursing assessment activities (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 6 of 15 individual</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Special Health Care Needs: <ul style="list-style-type: none"> • "Handicap bars for shower" (<i>Wording revised as result of the Informal Reconsideration of Findings process</i>). ◦ Individual #7 - According to Doctor's prescription dated 04/21/2009, the individual is required to have shower bars. • Initial Nutritional Evaluation <ul style="list-style-type: none"> ◦ Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. • Meal Time Plan <ul style="list-style-type: none"> ◦ Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. • Nutritional Plan <ul style="list-style-type: none"> ◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. ◦ Individual #9 - As indicated by the IST section of ISP the individual is required to have a plan. • Crisis Plans <ul style="list-style-type: none"> • Asthma <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan. • Cardiac Condition <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan. 	<p>Repeat Findings:</p> <p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 1 of 3 individual</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Special Health Care Needs: <ul style="list-style-type: none"> • Nutritional Plan <ul style="list-style-type: none"> ◦ Individual #9 - As indicated by the IST section of ISP the individual is required to have a plan.

PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request.

(c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first.

(d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy).

(e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as *subjective* information including the individual complaints, signs and symptoms noted by staff, family members or other team members; *objective* information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.

(2) Health related plans

(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional.

(b) Crisis prevention and intervention plans must be

- Ulcers
 - Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan.

- Sleep Apnea
 - Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan.

- Gastrointestinal
 - Individual #7 - As indicated by the IST section of ISP the individual is required to have a plan.

written in user-friendly language that is easily understood by those implementing the plan.

(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.

(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.

(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):

(a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.

(b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.

(c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan.

(d) Healthcare plans shall be written in language that

will be easily understood by the person(s) identified as implementing the interventions.

(e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings.

(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.

(g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author.

(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.

(4) General Nursing Documentation

(a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person.

(b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E	Scope and Severity Rating: E
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</p> <p>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 31 of 53 Direct Service Personnel.</p> <p>Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> • Pre- Service (DSP #23, 32 & 43) • Basic Health/Orientation (DSP #23, 32, 43, 47 & 68) • Person-Centered Planning (1-Day) (DSP #26, 27, 32, 43, 47, 51, 52, 55 & 68) • First Aid (DSP #20, 22, 23, 24, 26, 32, 44, 45, 54 & 64) • CPR (DSP #16, 20, 22, 23, 24, 26, 27, 28, 32, 34, 45, 54 & 64) • Assisting With Medications (DSP #16, 20, 26, 32, 33, 34, 44 & 54) • Rights & Advocacy (DSP #16, 20, 23, 25, 29, 37, 43, 47, 55 & 58) • Level 1 Health (DSP # 20, 29, 43, 57, 62 & 68) • Teaching & Support Strategies (DSP #23, 28, 29, 42, 43, 46, 47 & 68) • Positive Behavior Supports Strategies (DSP #47, 57, 62, & 63) • Participatory Communication & Choice Making (DSP #20, 23, 25, 29, 42, 43, 47, 55, 57, 63, 67 & 68) 	<p>New & Repeat Findings</p> <p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 7 of 28 Direct Service Personnel.</p> <p>Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> • Pre- Service (DSP #76) • Basic Health/Orientation (DSP #76 & 77) • Person-Centered Planning (1-Day) (DSP #76 & 77) • First Aid (DSP #76 & 77) • CPR (DSP #28, 76 & 77) • Rights & Advocacy (DSP #20 & 23) • Teaching & Support Strategies (DSP #23, 28 & 46) • Participatory Communication & Choice Making (DSP #25)

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	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> (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 DDS in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and (5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and 	<p>Based on interview, the Agency failed to ensure that training competencies were met for 5 of 16 Direct Service Personnel.</p> <p>When DSP were asked if they received training on the Individual's Speech Therapy Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #42 stated, "No, I am not trained." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #7) <p>When DSP were asked if they received training on the Individual's Health Care Plans and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #44 stated, "No, he does not have any." As indicated by the Agency file, the Individual has Health Care Plans for mobility, seizures, pain, GERD, nutrition, and anti-psychotic medications. (Individual #8) <p>When DSP were asked if they received training on the Individual's Crisis Plans and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #44 stated, "No." As indicated by the Agency file, the Individual has Crisis Plans for seizures. (Individual #8) <p>When DSP were asked, what steps did they need to take before assisting an individual with PRN medication, the following was reported:</p> <ul style="list-style-type: none"> • DSP #43 stated, "Call the nurse, after giving medication, it happens very seldom". According to DDS 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 	<p>Complete</p>

<p>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.</p> <p>(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:</p> <p>(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;</p> <p>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</p> <p>(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p>	<p>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 #7)</p> <ul style="list-style-type: none"> • DSP #18 stated, "Call the nurse or Gina". 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 #8) <p>When DSP were asked, what do you do if there is a medication error, the following was reported:</p> <ul style="list-style-type: none"> • DSP #52 stated, "I don't know". (Individual #13) 	
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Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D	Scope and Severity Rating: NA
<p>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</p> <p>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</p> <p>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: A. homicide; B. trafficking, or trafficking in controlled substances; C. kidnapping, false imprisonment, aggravated assault or aggravated battery; D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; E. crimes involving adult abuse, neglect or financial exploitation; F. crimes involving child abuse or neglect; G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p>	<p>Based on record review, the Agency failed to maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 2 of 56 Agency Personnel.</p> <p>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</p> <ul style="list-style-type: none"> • #36 – Date of hire 08/08/2008 <p>The following Agency Personnel Files contained Caregiver Criminal History Screenings, which were not specific to the Agency:</p> <ul style="list-style-type: none"> • #52 – Date of hire 04/01/2006 	<p>Complete</p>

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E	Scope and Severity Rating: D
<p>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p> <p>E. Documentation for other staff. With respect to all employed or contracted individuals</p>	<p>Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 13 of 56 Agency Personnel.</p> <p>The following Agency personnel records contained NO evidence of the Employee Abuse Registry being completed:</p> <ul style="list-style-type: none"> • #43 – Date of hire 10/01/2008 • #48 – Date of hire 07/01/2008 • #50 – Date of hire 04/01/2006 • #52 – Date of hire 04/01/2006 • #53 – Date of hire 04/01/2006 <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #22 – Date of hire 12/05/2008 • #32 – Date of hire 06/07/2009 • #38 – Date of hire 01/08/2008 • #39 – Date of hire 11/17/2007 • #40 – Date of hire 11/15/2007 • #41 – Date of hire 11/26/2007 • #42 – Date of hire 09/04/2008 • #45 – Date of hire 09/09/2006 	<p>New Findings:</p> <p>Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 1 of 29 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #75 – Date of hire 8/18/2009. Complete 8/22/2009.

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: D	Scope and Severity Rating: E
<p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>A. Duty To Report:</p> <p>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</p> <p>(2) All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:</p> <p>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</p> <p>(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.</p> <p>(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.</p> <p>B. Notification: (1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.</p>	<p>Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 16 individuals.</p> <p>Individual #73</p> <ul style="list-style-type: none"> Incident date 1/15/2009. Allegation was Neglect. Incident report was received 2/3/2009. Failure to Report. IMB Late & Failure Report indicated incident Neglect was "Confirmed." 	<p>New & Repeat Findings:</p> <p>Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 2 of 6 individuals.</p> <p>Individual #79</p> <ul style="list-style-type: none"> Incident date 3/8/2008. Allegation was Abuse, Neglect & Exploitation. Incident report was received 3/12/2010. Failure to Report. IMB Late & Failure Report indicated incident Neglect was "Confirmed." <p>Individual #80</p> <ul style="list-style-type: none"> Incident date 3/8/2008. Allegation was Abuse, Neglect & Exploitation. Incident report was received 3/12/2010. Late reporting. IMB Late & Failure Report indicated incident Neglect was "Confirmed."

Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: E	Scope and Severity Rating: NA
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</p> <p>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p>	<p>Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 21 of 56 Agency Personnel.</p> <ul style="list-style-type: none"> • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#16, 20, 24, 34, 41, 44, 46, 47, 53, 55, 57, 58, 59, 60, 61, 62, 63, 64 & 67) <p>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:</p> <ul style="list-style-type: none"> • DSP #48 stated, "I don't know. Maybe I had training. Did not say what agency." • DSP #49 stated, "I don't know." <p>When DSP were asked to give examples of Abuse, Neglect & Misappropriation of Consumers' Property, the following was reported:</p> <ul style="list-style-type: none"> • DSP #44 stated, "I don't know." • DSP #49 stated, "I don't know." 	<p>Complete</p>

Tag # 1A28 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: E	Scope and Severity Rating: NA
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>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.</p>	<p>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 5 of 15 individuals.</p> <ul style="list-style-type: none"> • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#3, 6, 7, 8 & 11) 	<p>Complete</p>

Tag # 1A28 (CoP) Incident Mgt. System - Posters	Scope & Severity Rating: E	Scope and Severity Rating: NA
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>F. Posting of Incident Management Information Poster: All licensed health care facilities and community based service providers shall post two (2) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. All licensed health care facilities and community based service providers operating sixty (60) or more beds shall post three (3) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. The posters shall be posted where employees report each day and from which the employees operate to carry out their activities. Each licensed health care facility or community based service provider shall take steps to insure that the notices are not altered, defaced, removed, or covered by other material. [7.1.13.10 NMAC - N, 02/28/06]</p>	<p>Based on observation, the Agency failed to post two (2) or more Incident Management Information posters in a prominent public location for the following locations for 5 of 14 residences:</p> <p>The following locations were identified:</p> <p>Residence of :</p> <ul style="list-style-type: none"> • Individual #3 • Individual #5 • Individual #9 • Individual #11 • Individual #13 	<p>Complete</p>

Tag # 1A29 Complaints / Grievances - Acknowledgement	Scope and Severity Rating: A	Scope and Severity Rating: NA
<p>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].</p> <p>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]</p> <p>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</p>	<p>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 15 individuals.</p> <ul style="list-style-type: none"> Grievance/Complaint Procedure Acknowledgement (#8) 	<p>Complete</p>

Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: F	Scope and Severity Rating: NA
<p>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:</p> <p>A. A service provider shall not restrict or limit a client's rights except:</p> <p>(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or</p> <p>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or</p> <p>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].</p> <p>B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy.</p> <p>C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p>Long Term Services Division Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003 - IV. POLICY STATEMENT - Human Rights Committees are required for residential service provider agencies. The purpose of these 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</p>	<p>Based on record review, the Agency failed to follow DDSD Policy regarding Human Rights Committee Requirements.</p> <p>Review of the Agency Policy & Procedure found the policy did not address Behavior Support Plans approved by the Human Rights Committee are to be reviewed at least quarterly.</p> <p>The Agency's policy & procedure stated, the following:</p> <p>"The Human Rights Committee will meet at least annually or more often as needed." The last documented date for revisions/review is 12/2001.</p> <p>When asked if the Agency had a Human Rights Committee or was part of a Regional HRC, the following was reported:</p> <p>#72 stated, "Depending on the region, we either have our own or are part of a Regional HRC. We only meet 2 or 3 times per year or as needed."</p>	<p>Complete</p>

following policies:

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

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

A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS

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

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

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

Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:

Medication Assessment and Delivery Procedure

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

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: E	Scope and Severity Rating: NA
<p>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<p>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 12 of 15 individuals.</p> <p>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #6</p> <ul style="list-style-type: none"> • None found for 7/2009 - 9/2009 <p>Individual #12</p> <ul style="list-style-type: none"> • None found for 10/2008 - 10/2009 <p>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #1</p> <ul style="list-style-type: none"> • None found for 10/2008 - 10/2009 <p>Individual #2</p> <ul style="list-style-type: none"> • None found for 10/2008 - 10/2009 <p>Individual #3</p> <ul style="list-style-type: none"> • None found for 9/2009 - 10/2009 <p>Individual #4</p> <ul style="list-style-type: none"> • None found for 10/2008 - 10/2009 <p>Individual #9</p> <ul style="list-style-type: none"> • None found for 7/2009 - 9/2009 <p>Individual #10</p> <ul style="list-style-type: none"> • None found for 10/2008 - 10/2009 <p>Individual #11</p> <ul style="list-style-type: none"> • None found for 10/2008 - 10/2009 	<p>Complete</p>

- Individual #13
- None found for 10/2008 - 10/2009
- Individual #14
- None found for 10/2008 - 10/2009
- Individual #15
- None found for 7/2009

Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

- Individual #10
- None found for 10/2008 - 10/2009
- Individual #12
- None found for 10/2008 - 10/2009
- Individual #14
- None found for 10/2008 - 10/2009

Tag # 1A33 Board of Pharmacy - Lic	Scope and Severity Rating: C	Scope and Severity Rating: NA
<p>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual</p> <p>6. Display of License and Inspection Reports</p> <p>A. The following are required to be publicly displayed:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Current Custodial Drug Permit from the NM Board of Pharmacy <input type="checkbox"/> Current registration from the consultant pharmacist <input type="checkbox"/> Current NM Board of Pharmacy Inspection Report 	<p>Based on observation, the Agency failed to provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 1 of 2 residences:</p> <p>Individual Residence:</p> <ul style="list-style-type: none"> • Current Custodial Drug Permit from the NM Board of Pharmacy (#6) • Current NM Board of Pharmacy Inspection report (#6) 	<p>Complete</p>

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: D	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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.</p> <p>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</p>	<p>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 3 of 56 Agency Personnel.</p> <p>Review of personnel records found no evidence of the following:</p> <ul style="list-style-type: none"> • Individual Specific Training (#28, 55 & 60) 	<p>Complete</p>

Tag #1A40 - Provider Requirement Accreditation	Scope and Severity Rating: C	Scope and Severity Rating: NA
<p>NMAC 7.26.6.6 OBJECTIVE: A. These regulations are being promulgated to promote and assure the provision of quality services...</p> <p>B. These regulations are being promulgated as part of a quality assurance initiative requiring all community agencies providing services to persons with developmental disabilities and contracting with the developmental disabilities division to be accredited by the commission on accreditation of rehabilitation facilities (CARF).</p> <p>7.26.6.14 CARF STANDARDS MANUAL FOR ORGANIZATIONS SERVING PEOPLE WITH DEVELOPMENTAL DISABILITIES: Community agencies governed by these regulations are required to meet applicable provisions of the most current edition of the "CARF..." Sections of the CARF standards may be waived by the Department when deemed not applicable to the services provided by the community agency.</p> <p>Long Term Services Division Policy - Accreditation of Long Term Services Division Funded Providers eff. August 30, 2004 - A. Mandate for Accreditation The Department of Health, Long Term Services Division...will contract only with agencies/organizations accredited in compliance with this policy.</p> <p>1. Within eighteen (18) months of an initial contract or change in exemption status as defined in this policy, the contractor must provide the Division with written verification of accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and Leadership in Supports for People with Disabilities (The Council).</p> <p>2. Except as provided in this policy, the Division may terminate its contract with a contractor that fails to maintain an accreditation status of at least one year, regardless of any appeal process available from CARF or the Council.</p>	<p>Based on observation and interview, the Agency failed to obtain the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and Leadership in Supports for People with Disabilities (The Council) accreditation or the applicable waiver from the Developmental Disability Support Division.</p> <p>When asked if the Agency had evidence of current CARF accreditation or a waiver from DDSD the following was reported:</p> <p>#72 stated, "I sent them a request for an exemption."</p> <p>As indicated by a letter from the Agency dated June 10, 2009, a request was made to DDSD for exemption. However, during the on-site survey the Agency was unable to provide evidence the exemption was granted. CARF accreditation expired April 2009.</p>	<p>Complete</p>

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Scope and Severity Rating: B	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS</p> <p>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:</p> <p>(1) Identification and implementation of a meaningful day definition for each person served;</p> <p>(2) Documentation summarizing the following:</p> <p>(a) Daily choice-based options; and</p> <p>(b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP.</p> <p>(3) Significant changes in the individual's routine or staffing;</p> <p>(4) Unusual or significant life events;</p> <p>(5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs;</p> <p>(6) Record of personally meaningful community inclusion;</p> <p>(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</p> <p>(8) Any additional reporting required by DDSD.</p>	<p>Based on record review, the Agency failed to complete quarterly reports as required for 2 of 8 individuals receiving Community Inclusion services.</p> <p>Adult Habilitation Quarterly Reports</p> <ul style="list-style-type: none"> • Individual #10 - None found for 10/2008 - 10/2009 • Individual #14 - None found for 10/2008 - 10/2009 	<p>Resolved as a result of the Informal Reconsideration of Findings process for Individual #14. Remainder of finding complete.</p>

Tag # 5144 AH Reimbursement	Scope and Severity Rating: B	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 XVI. REIMBURSEMENT</p> <p>A. Billable Unit. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care.</p> <p>B. Billable Activities</p> <p>(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.</p> <p>(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</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 5 of 8 individuals.</p> <p>Individual #7 August 2009</p> <ul style="list-style-type: none"> The Agency billed 310 units of Adult Habilitation from 8/01/2009 through 8/31/2009. Documentation received accounted for 266 units. <p>Individual #8 July 2009</p> <ul style="list-style-type: none"> The Agency billed 464 units of Adult Habilitation from 7/01/2009 through 7/31/2009. Documentation received accounted for 408 units. <p>August 2009</p> <ul style="list-style-type: none"> The Agency billed 166 units of Adult Habilitation from 8/01/2009 through 8/31/2009. Documentation received accounted for 158 units. <p>Individual #10 July 2009</p> <ul style="list-style-type: none"> The Agency billed 520 units of Adult Habilitation from 7/01/2009 through 7/31/2009. Documentation received accounted for 504 units. <p>Individual #11 July 2009</p> <ul style="list-style-type: none"> The Agency billed 48 units of Adult Habilitation from 7/01/2009 through 7/31/2009. No documentation found to justify billing. <p>August 2009</p>	<p>Complete</p>

	<ul style="list-style-type: none"> • The Agency billed 104 units of Adult Habilitation from 8/01/2009 through 8/31/2009. No documentation found to justify billing. <p>Individual #13 July 2009</p> <ul style="list-style-type: none"> • The Agency billed 480 units of Adult Habilitation from 7/01/2009 through 7/31/2009. No documentation found to justify billing. <p>August 2009</p> <ul style="list-style-type: none"> • The Agency billed 480 units of Adult Habilitation from 8/01/2009 through 8/31/2009. No documentation found to justify billing. 	
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Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: F	Scope and Severity Rating: D
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES</p> <p>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...</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS</p> <p>D. Scope of DDSD Agreement</p> <p>(4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite;</p> <p>NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY- BASED SERVICES WAIVER - ELIGIBLE PROVIDERS:</p> <p>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.</p> <p>(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.</p>	<p>Based on record review, the Agency failed complete all DDSD requirements for approval for 12 of 12 of each direct support provider individuals.</p> <p>The following was not found, not current and/or incomplete:</p> <ul style="list-style-type: none"> • Current Family Living Contract (<i>Agency contract did not specify an end date</i>) (#1, 2, 3, 4, 5, 7, 9, 10, 11, 13, 14 & 15) 	<p>Repeat Findings:</p> <p>Based on record review, the Agency failed complete all DDSD requirements for approval for 1 of 3 of each direct support provider individuals.</p> <p>The following was not found, not current and/or incomplete:</p> <ul style="list-style-type: none"> • Current Family Living Contract (#11)

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</p> <p>G. Health Care Requirements for Community Living Services.</p> <p>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first.</p> <p>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <p>(a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by</p>	<p>Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 4 of 15 individuals receiving Community Living Services.</p> <ul style="list-style-type: none"> • Annual Physical (#13) • Vision Exam <ul style="list-style-type: none"> ◦ Individual #15 - As indicated by the documentation reviewed, exam was completed on 11/05/2007. Follow-up was to be completed in 24 months. No evidence of follow-up found. • Abnormal Involuntary Movement Screening <ul style="list-style-type: none"> ◦ None found 4/2009 – Strattera & Risperdal (#2) ◦ None found 4/2009 - Zyprexa (#11) • Colonoscopy <ul style="list-style-type: none"> ◦ Individual #15 - As indicated by the documentation reviewed, the exam was ordered on 7/01/2009. No evidence of exam was found. 	<p>Complete</p>

<p>a licensed nurse.</p> <p>(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <p>(a) The individual has a primary licensed physician;</p> <p>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</p> <p>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</p> <p>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</p> <p>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</p>		
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Tag # 6L14 Residential Case File	Scope and Severity Rating: E	Scope and Severity Rating: D
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>A. Residence Case File: For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:</p> <p>(1) Complete and current ISP and all supplemental plans specific to the individual;</p> <p>(2) Complete and current Health Assessment Tool;</p> <p>(3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;</p> <p>(4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);</p> <p>(5) Data collected to document ISP Action Plan implementation</p> <p>(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 11 of 14 Individuals receiving Family Living Services or Supported Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ Did not contain Pharmacy Information (#10 & 11) • Annual ISP (#2, 9, 12 & 14) • ISP Signature Page (#1, 2, 9 & 14) • Addendum A (#1, 2, 4, 7, 9, 10 & 11) • Teaching & Support Strategies (#1, 2, 4, 7, 10, 11, 12 & 14) • Individual Specific Training (Addendum B) (#1) • Positive Behavioral Plan (#1, 5 & 7) • Positive Behavioral Crisis Plan (#7) • Speech Therapy Plan (#5, 11 & 12) • Occupational Therapy Plan (#2 & 5) • Physical Therapy Plan (#1, 4, & 9) • Health Assessment Tool (#1, 2, 4, 5, 9, 11, 12, 14 & 15) • Special Health Care Needs <ul style="list-style-type: none"> ◦ Nutritional Plan (#4) 	<p>Repeat Findings:</p> <p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 1 of 3 Individuals receiving Family Living Services or Supported Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Teaching & Support Strategies (#11)

(9) Medication Administration Record (MAR) for the past three (3) months which includes:

- (a) The name of the individual;
- (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;
- (c) Diagnosis for which the medication is prescribed;
- (d) Dosage, frequency and method/route of delivery;
- (e) Times and dates of delivery;
- (f) Initials of person administering or assisting with medication; and
- (g) An explanation of any medication irregularity, allergic reaction or adverse effect.
- (h) For PRN medication an explanation for the use of the PRN must include:
 - (i) Observable signs/symptoms or circumstances in which the medication is to be used, and
 - (ii) Documentation of the effectiveness/result of the PRN delivered.
- (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis.

(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and

(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.

- **Health Care Plans**
 - Cardiac Condition (#4)
 - Ulcers (#4)
 - Seizures (#2)
 - Sleep Apnea (#2)
- **Crisis Plan**
 - Allergies (#7)
 - Gastrointestinal (#7)
 - Seizures (#2 & 9)
- **Progress Notes/Daily Contacts Logs:**
 - Individual #4 - None found for October 2009
 - Individual #9 - None found for October 2009
 - Individual #14 - None found for October 2009
 - Individual #15 - None found for October 2009
- **Data Collection/Data Tracking:**
 - Individual #4 - None found for October 2009
 - Individual #12 - None found for October 2009
 - Individual #15 - None found for October 2009
- **Progress Notes written by DSP and/or Nurses regarding Health Status:**
 - Individual #1 - None found for October 2009
 - Individual #4 - None found for October 2009
- Health Care Providers Written Orders (#15)
- Record of visits of healthcare practitioners (#5)

Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: F	Scope and Severity Rating: D
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>L. Residence Requirements for Family Living Services and Supported Living Services</p> <p>(1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has:</p> <ul style="list-style-type: none"> (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence; (b) General-purpose first aid kit; (c) When applicable due to an individual's health status, a blood borne pathogens kit; (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats; (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone; (f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift; (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. 	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 13 of 14 Supported Living & Family Living residences.</p> <p>The following items were not found, not functioning or incomplete:</p> <p>Supported Living:</p> <ul style="list-style-type: none"> • General-purpose first aid kit (#12) • 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 (#6 & 12) • Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#12) • 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 (#12) • 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 (#12) <p>Family Living:</p> <ul style="list-style-type: none"> • General-purpose first aid kit (#3) 	<p>Repeat Findings:</p> <p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 1 of 3 Family Living residences.</p> <p>The following items were not found, not functioning or incomplete:</p> <p>Family Living:</p> <ul style="list-style-type: none"> • 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 (#9) • 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 (#9)

	<ul style="list-style-type: none"> • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#4 & 10) • 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 (#4, 5 & 10) • Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#5 & 10) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#1, 2, 3, 4, 5, 7, 9, 10, 11 & 13) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 3, 5, 9, 10, 11 & 13) 	
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