Date:	February 8, 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:	Southeast & Southwest
Survey Date:	November 30 – December 1, 2009
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Community Living (Family Living)
Survey Type:	Routine
Team Leader:	Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Cindy Preston, Community Inclusion Coordinator, Developmental Disability Supports Division & Dave L. Brunson, Community Inclusion Coordinator, Developmental Disability Supports Division

Dear Ms., Kalter

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

Quality Management Approval Rating:
The Division of Health Improvement/Quality Management Bureau is issuing your agency a "SUB-STANDARD" rating for significant non-compliance with DDSD Standards and regulations; additionally your agency is being referred to the Internal Review Committee for consideration of remedies and possible sanctions.

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

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

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

Upon notification from QMB that your Plan of Correction has been approved, you must implement all remedies and corrective actions within 45 working days. If your plan of correction is denied, you must resubmit a revised plan ASAP for approval. All remedies must still be completed within 45 working days of the original submission.

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

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

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

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

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

This IRF process is separate and apart from the Informal Dispute Resolution (IDR) and Fair Hearing Process for Sanctions from DOH.

Please call the Team Leader at 505-231-7436 if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

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

Survey Process Employed:

Entrance Conference Date:	November 30, 2009
Present:	**New Pathways Inc.** Maya Barela, Service Coordinator **DOH/DHI/QMB** Tony Fragua, BFA, SE & SW Team Lead/Healthcare Surveyor Deb Russell, BS, Healthcare Surveyor **DDSD – SE & SW Regional Office** Cindy Preston, Community Inclusion Coordinator Dave L. Brunson, Community Inclusion Coordinator
Exit Conference Date:	December 1, 2009
Present:	**New Pathways Inc.** Connie Kalter, Executive Director Maya Barela, Service Coordinator Stacy Kalter, Family Living Director **DOH/DHI/QMB** Tony Fragua, BFA, SE & SW Team Lead/Healthcare Surveyor Deb Russell, BS, Healthcare Surveyor **DDSD - SW Regional Office** Scott Doan, Regional Director Dave L. Brunson, Community Inclusion Coordinator
Homes Visited	Number: 4
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 4 4 - Non-Jackson Class Members 4 - Family Living
Persons Served Interviewed	Number: 4
Records Reviewed (Persons Served)	Number: 4
Administrative Files Reviewed	• Billing Records • Medical Records • Incident Management Records • Personnel Files • Training Records • Agency Policy and Procedure • Caregiver Criminal History Screening Records • Employee Abuse Registry • Human Rights Notes and/or Meeting Minutes • Nursing personnel files • Evacuation Drills • Quality Improvement/Quality Assurance Plan

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

Attachment A

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8647.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency ("Responsible Party"), and by WHEN ("Date Due").
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues to prevent the Deficiency from reoccurring, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency's Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to George.Perrault@state.nm.us, by fax (505-222-8661), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been "Approved" or "Denied".
- Whether your POC is "Approved" or "Denied", you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is "Denied" it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- The following Deficiencies must be corrected within the deadlines below (after receipt of your Survey Report):

    - CCHS and EAR: 10 working days
    - Medication errors: 10 working days
    - IMS system/training: 20 working days
    - ISP related documentation: 30 working days
    - DDSD Training 45 working days

- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8647 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.
- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by-case basis.
- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual #s.
- Do not submit original documents, hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Attachment B

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

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

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

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

Key to Severity scale:
Low Impact Severity: (Blue)
Low level findings have no or minimal potential for harm to an individual. Providers that have no findings above a "C" level may receive a "Quality" Certification approval rating from QMB.

Medium Impact Severity: (Tan)
Medium level findings have a potential for harm to an individual. Providers that have no findings above a "F" level and/or no more than two F level findings and no F level Conditions of Participation may receive a "Merit" Certification approval rating from QMB.

High Impact Severity: (Green or Yellow)
High level findings are when harm to an individual has occurred. Providers that have no findings above "I" level may only receive a "Standard" Approval rating from QMB and will be referred to the IRC.

High Impact Severity: (Yellow)
"J, K, and L" Level findings:
This is a finding of Immediate Jeopardy. If a provider is found to have "I" level findings or higher, with an outcome of Immediate Jeopardy, including repeat findings or Conditions of Participation they will be referred to the Internal Review Committee.

The QMB Approval Rating

The QMB approval rating is the provider incentive to encourage quality service and correlates the review outcome with the QMB review frequency and its recommendation to DDSD to determine the length of the provider agreement. The "Approval rating" is based on the Scope and Severity of the review findings. There are five levels of "Approval" that a provider may receive. They are:

"Quality" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Quality" Rating. To qualify for a QMB "Quality" rating of approval" and a three (3) year QMB review cycle and provider agreement recommendation, the provider must not have any findings that are a condition of participation and no findings of "F" level or higher on the Scope and Severity Matrix with no more that three (3) D or E level findings.

"Merit" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Merit" Rating. To qualify for a QMB "Merit" rating of approval" and a two (2) year QMB review cycle and provider agreement recommendation, the provider must not have more than three (3) findings that are a condition of participation and no more than three (3) "F" level findings with no findings of a "G" level or higher on the Scope and Severity Matrix and no more that six (6) D or E level findings.

"Standard" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Standard" Rating. To qualify for a QMB "Standard" rating of approval" and a one (1) year QMB review cycle and provider agreement recommendation, the provider must not have more than six (6) findings that are a condition of participation and no more than six (6) "F" level findings with no findings of a "G" level or higher on the Scope and Severity Matrix and no more that six (6) D or E level findings.

"Sub-Standard" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider has "Sub-standard" performance. To qualify for a QMB "Sub-Standard" rating of approval" and a three to six month QMB review cycle, with a referral to the Internal Review Committee and provider agreement recommendation, the provider may have any of the following findings:

- seven (7) or more findings that are a condition of participation
- seven (7) or more "F" level findings
- any findings of a "G" level or higher
- nine (9) or more D or E level findings

A referral to the IRC is required for any "Sub-standard" rating. Depending upon the egregious nature of the findings the IRC shall take appropriate sanction actions up to and including contract termination.

"Provisional" Approval Rating:
New DD service providers may qualify for a QMB "Provisional" Approval Rating upon successfully completing their initial QMB Quality Survey.
The QMB DD Manager will review the Report of Findings and determine if the provider has achieved at least a standard rating of approval. If successful, the provider may receive a one (1) year contract extension. QMB will notify the DDSD Contract unit of the "Provisional" approval rating.

Attachment C

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

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

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

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

The following limitations apply to the IRF process:

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

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

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

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

Administrative Review Process:
If a Provider desires to challenge the decision of the IRF committee they may request an Administrative Review by the DHI and DDSD Director. The Request must be made in writing to the QMB Bureau Chief and received within 5 days of notification from the IRF decision.

Regarding IRC Sanctions:
The Informal Reconsideration of the Finding process is a separate process specific to QMB Survey Findings and should not be confused with any process associated with IRC Sanctions.

If a Provider desires to Dispute or Appeal an IRC Sanction that is a separate and different process. Providers may choose the Informal Dispute Resolution Process or the Formal Medicaid Fair Hearing Process to dispute or appeal IRC sanctions, please refer to the DOH Sanction policy and section 39 of the provider contract agreement.

Agency: **New Pathways, Inc. - Southeast & Southwest Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Family Living)
Monitoring Type: Routine Survey
Date of Survey: **November 30 – December 1, 2009**

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A03 CQI System	**Scope and Severity Rating: C**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS** **I. Continuous Quality Management System:** Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (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	Based on record review, the Agency failed to develop and implement a Continuous Quality Management System. Review of the Agency's Continuous Quality Improvement Plan provided during the on-site survey did not contain the components required by Standards. The Agency's General CQI Plan did not contain details on how the following components will be achieved: (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 **When #53 was asked about the Agency's General CQI Plan the following was reported:** #53 stated, "Our process is not 100%. It depends		

supervisory and direct support levels; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction. **7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:** **E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system: **(1)** community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements; **(2)** community based service providers providing developmental disabilities services must have a designated incident management coordinator in place; **(4)** community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.	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." **The Agency's Incident Management CQI Plan did not contain the following components:** (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; (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. **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:** #53 stated, "As a whole agency, we look at trends informally. We do not keep minutes and do not have a formal committee."		

Tag # 1A05 (CoP) General Requirements	Scope and Severity Rating: F		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1** II**. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **A. General Requirements:** (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 DDSD 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.	Based on record review, the Agency failed to review and update its written policies and procedures every three years or as needed. 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: • "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. • "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 expenditures on behalf of a Consumer" - Last reviewed and/or revised 08/2003. • "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.		

Tag # 1A08 Agency Case File	Scope and Severity Rating: B		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 3 of 4 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • **Annual ISP** ° Not Found (#4) • **ISP Teaching & Support Strategies** ° Individual #4 - TASS not found: ➢ "(#4) will reframe from talking until commercial breaks" • ISP Signature Page (#4 & 3) • Addendum A (#4) • Individual Specific Training Section (ISP) (#4) • Positive Behavioral Crisis Plan (#4) • Speech Therapy Plan (#1) • Physical Therapy Plan (#4 & 3)		

developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.			

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and	Medication Administration Records (MAR) were reviewed for the months of August, September & October 2009. Based on record review, 2 of 4 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #2 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: • Carbatral 200mg (2 times daily) • Lamictal 100mg (2 times daily) Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Lamictal 100mg (2 times daily) – Blank 8/5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20,21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (7:30 AM) – Blank 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (7 PM) 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: • Carbatral 200mg (2 times daily) • Lamictal 100mg (2 times daily) October 2009		

(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff	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: • Carbatral 200mg (2 times daily) • Lamictal 100mg (2 times daily) Individual #3 August, 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Levothyroid 75mcd (1 time daily) September, 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Levothyroid 75mcd (1 time daily) • Lovastatin 20mg (1 time daily) October, 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Levothyroid 75mcd (1 time daily) • Lovastatin 20mg (1 time daily)		

administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period.			

Tag # 1A09 Medication Delivery - PRN Medication	Scope and Severity Rating: F		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 4 of 4 Individuals. Individual #1 August 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the dosage for the following medications:		

(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued	• Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) September 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN)		

or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period. **Department of Health** **Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006** **F. PRN Medication** 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.	Medication Administration Records did not contain the dosage for the following medications: • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) October 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN)		

4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention.	• Milk of Magnesia (PRN) Medication Administration Records did not contain the dosage for the following medications: • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Individual #2 August 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN)		

(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.).	• Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the dosage for the following medications: • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) September 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN)		

	• Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the dosage for the following medications: • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) October 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN)		

	• Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the dosage for the following medications: • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 325mg – PRN – 10/14 & 10/15 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 325mg – PRN – 10/14 & 10/15 (given 1 time daily) Individual #3 August 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN)		

	• Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the dosage for the following medications: • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) September 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 325mg (PRN)		

	• Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the dosage for the following medications: • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) October 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:		

	• Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the dosage for the following medications: • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Individual #4 August 2009		

	Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 325mg (PRN) • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN) Medication Administration Records did not contain the dosage for the following medications: • Imodium (B) (PRN) • Mylanta (B) (PRN) • Robitussin (B) (PRN) • Pepto Bismul (PRN) • Milk of Magnesia (PRN)		

	No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Motrin 200mg – PRN – 8/7, 17, 26 & 31 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Motrin 200mg – PRN – 8/7, 17, 26 & 31 (given 1 time daily) September 2009 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Motrin 200mg – PRN – 9/16 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Motrin 200mg – PRN – 9/16 (given 1 time daily)		

Tag # 1A12 Reimbursement/Billable Units	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.	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 4 of 4 individuals. Individual #1 August 2009 • The Agency billed 31 units of Family Living Services from 8/1/2009 through 8/31/2009. Documentation did not contain start and end time and a signature/authenticated name of the staff providing the service to justify billing. September 2009 • The Agency billed 30 units of Family Living Services from 9/1/2009 through 9/30/2009. Documentation did not contain start and end time to justify billing. Billing units were unable to be verified, Individual was not included on remittance forms provided. October 2009 • The Agency billed 31 units of Family Living Services from 10/1/2009 through 10/31/2009. Documentation did not contain start and end time to justify billing. Billing units were unable to be verified, Individual was not included on remittance forms provided. Individual #2 September 2009 • Documentation provided accounted for 30 units of Family Living Services from 09/1/2009 through 09/30/2009. Billing units were unable to be verified, Individual was not included on remittance forms provided. October 2009 • Documentation provided accounted for 31 units of Family Living Services on 10/1/2009 through 10/31/2009. Billing units were unable		

	to be verified, Individual was not included on remittance forms provided. Individual #3 August 2009 • The Agency billed 31 units of Family Living Services from 8/1/2009 through 8/31/2009. Documentation did not contain start and end time and a signature/authenticated name of the staff providing the service to justify billing. September 2009 • The Agency billed 30 units of Family Living Services from 9/1/2009 through 8/30/2009. Documentation did not contain start and end time to justify billing. Billing units were unable to be verified, Individual was not included on remittance forms provided. October 2009 • The Agency billed 31 units of Family Living Services from 10/1/2009 through 10/31/2009. Documentation did not contain start and end time to justify billing. Billing units were unable to be verified, Individual was not included on remittance forms provided. Individual #4 August 2009 • The Agency billed 31 units of Family Living Services from 8/1/2009 through 8/31/2009. Documentation did not contain start and end time to justify billing. September 2009 • The Agency billed 30 units of Family Living Services from 9/1/2009 through 9/30/2009. Documentation did not contain start and end time to justify billing. Billing units were unable to be verified, Individual was not included on remittance forms provided.		

	October 2009 • The Agency billed 31 units of Family Living Services from 10/1/2009 through 10/31/2009. Documentation did not contain start and end time to justify billing. Billing units were unable to be verified, Individual was not included on remittance forms provided.		

Tag # 1A15 Nurse Availability	Scope and Severity Rating: D		
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** **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. **NEW MEXICO NURSING PRACTICE ACT CHAPTER 61, ARTICLE 3** I. "licensed practical nursing" means the practice of a directed scope of nursing requiring basic knowledge of the biological, physical, social and behavioral sciences and nursing procedures, which practice is at the direction of a registered nurse, physician or dentist licensed to practice in this state. This practice includes but is not limited to: (1) contributing to the assessment of the health status of individuals, families and communities; (2) participating in the development and modification of the plan of care; (3) implementing appropriate aspects of the plan of care commensurate with education and verified competence; (4) collaborating with other health care professionals in the management of health care; and (5) participating in the evaluation of responses to interventions;	Based on interview, the Agency failed to ensure nursing services were available as needed for 1 of 4 individuals. **When DSP were asked about the availability of their agency nurse, the following was reported:** • DSP #50 stated, "Not that I know of."		

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services…Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific … training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 9 of 12 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre-Service (DSP #51) • Basic Health/Orientation (DSP #51) • First Aid (DSP #40, 41, 45 & 46) • CPR (DSP #46, 48 & 50) • Assisting With Medication Delivery (DSP #50) • Level 1 Health (DSP #43 & 44) • Participatory Communication & Choice Making (DSP #43, 44 & 50)		

Tag # 1A22 Staff Competence	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **F. Qualifications for Direct Service Personnel:** The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency: (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy	Based on interview, the Agency failed to ensure that training competencies were met for 2 of 4 Direct Service Personnel. **When DSP were asked if they received training on the Individual's ISP and what the plan covered, the following was reported:** • DSP #48 stated, "Not specifically (#3's) ISP, no, I was told that I didn't need it." (Individual #3) **When DSP was asked if there was anyone you had to call, the following was reported:** • DSP #48 stated, "No." According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP) (Individual #3) **When DSP were asked what you are supposed to do if there is a medication error (missed dose and dropped pill), the following was reported:** • DSP #42 stated, "Call in report, call Poison Control depending on medication. For dropped medication we throw those away." According to agencies Medication Policy for Handling Contaminated/ Refused/ Discontinued Medication; The Consulting Pharmacist is the only person who destroys Medication.(Individual #4)		

Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and (5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support. (6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows: (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.			

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E		
NMAC 7.1.12.8 **REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED**: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.	Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 4 of 13 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry being completed:** • #51 – Date of hire 9/4/2009 **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** • #42 – Date of hire 9/01/2006 • #43 – Date of hire 8/18/2008 • #52 – Date of hire 9/01/2006		

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

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

Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: F		
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] **Long Term Services Division** **Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003** **IV. POLICY STATEMENT -** Human Rights Committees are required for residential service provider agencies. The purpose of these	Based on record review and interview, the Agency failed to follow DDSD Policy regarding Human Rights Committee Requirements. 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. The Agency's policy & procedure stated, the following: "The Human Rights Committee will meet at least annually or more often as needed." The last documented date for revisions/review is 12/2001. When asked if the Agency had a Human Rights Committee or was part of a Regional HRC, the following was reported: #53 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." **A review of Agency Individual files indicated 1 of 4 Individuals required Human Rights Committee Approval for restrictions.** No documentation was found regarding Human Rights Approval for the following: • Psychotropic Medications to control behaviors. No evidence found of Human Rights Committee approval. (Individual #4)		

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

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

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: D		
NMAC 7.26.5.16.C and D **Development of the ISP. Implementation of the ISP.** The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 4 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • Live Outcome: Individual will be able to make a purchase independently within 3 years. Action Step: Individual will learn addition/subtraction. Action Step is to be completed weekly. Action Step was not being completed at the required frequency for 8/2009 – 9/2009.		

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (2) **Individual-specific training** for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** **A.** Individuals shall receive services from competent and qualified staff. **B.** Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.	Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 7 of 13 Agency Personnel. Review of personnel records found no evidence of the following: • Individual Specific Training (#41, 43, 44, 45, 46, 48 & 49)		

Tag #1A40 - Provider Requirement Accreditation	Scope and Severity Rating: C		
NMAC 7.26.6.6 OBJECTIVE: A. These regulations are being promulgated to promote and assure the provision of quality services to persons with developmental disabilities residing in community agencies. 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). **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 Standards Manual for Organizations Serving People with Disabilities". Sections of the CARF standards may be waived by the Department when deemed not applicable to the services provided by the community agency. **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 (hereafter referred to as the Division) will contract only with agencies/organizations accredited in compliance with this policy. 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). 2. Except as provided in this policy, the Division may terminate its contract with a contractor that fails	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. **When asked if the Agency had evidence of current CARF accreditation or a waiver from DDSD the following was reported:** #53 stated, "I sent them a request for an exemption." 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.		

to maintain an accreditation status of at least one year, regardless of any appeal process available from CARF or the Council.			

Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: F		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES** **B**. **Home Studies**. The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS** **D. Scope of DDSD Agreement** (4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite; **NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER - ELIGIBLE PROVIDERS:** I. **Qualifications for community living service providers:** There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards. (1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be	Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 4 of 4 individuals. The following was not found, not current and/or incomplete: • Family Living (Annual Update) Home Study (#1, 2, 3 & 4) • Current Family Living Contract *(Agency contract did not specify an end date)* (#1, 2, 3 & 4)		

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

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6	Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 2 of 4 individuals receiving Community Living Services. • **Dental Exam** ° Individual #1 - As indicated by the documentation reviewed, exam was completed on 2/4/2009. Follow-up was to be completed in 4 months. No evidence of follow-up found. • **Vision Exam** ° Individual #1 - As indicated by the documentation reviewed, exam was completed on 8/16/2005. Follow-up was to be completed in 2 years per Doctors note. No evidence of follow-up found. • **Review of Psychotropic Medication** ° Individual #4 - According to Agency Case File Individual #4 is to have a medication review yearly. No evidence was found for the following time frame to indicate they were completed (11/2008 - 11/2009).		

on the HAT, has a Health Care Plan developed by a licensed nurse. (c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition. (4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT. (5) That the physical property and grounds are free of hazards to the individual's health and safety. (6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following: (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).			

Tag # 6L14 Residential Case File	Scope and Severity Rating: F		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 4 of 4 Individuals receiving Family Living Services. The following was not found, incomplete and/or not current: • Annual ISP (#3) • Teaching and Support Strategies (#2, 3 & 4) • ISP Signature Page (#3) • Addendum A (#3) • Individual Specific Training (Addendum B) (#3) • Speech Therapy Plan (#1 & 3) • Physical Therapy Plan (#3) • Health Assessment Tool (#3) • **Special Health Care Needs** ° Nutritional Plan (#3) • **Health Care Plans** ° Anxiety (#4) ° Deep Vein Thrombosis (#3) ° Fluid Intake (#4) ° Hypothyroidism (#3) ° Neurogenic Bowel and Bladder (#4) ° Risk for Falls/Injury (#4) ° Pain related to Scoliosis (#4) ° Seizures (#3 & 4) ° Suprapublic Catheter (#4) ° Osteoporosis (#3) • **Crisis Plan**		

a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital	° Seizures (#2 & 3) • **Progress Notes/Daily Contacts Logs:** ° Individual #1 - None found for November 2009 ° Individual #2 - None found for November 2009 ° Individual #3 – None found for November 2009 • **Data Collection/Data Tracking:** ° Individual #3 - None found for November 2009 • **Progress Notes written by DSP and/or Nurses regarding Health Status:** ° Individual #3 - None found for November 2009		

discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.			

Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports)	Scope and Severity Rating: A		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **D. Community Living Service Provider Agency Reporting Requirements:** All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation: (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members.	Based on record review, the Agency failed to complete written quarterly status reports for 1 of 4 individuals receiving Community Living Services. **Family Living Quarterly Reports:** • Individual # - None found for 8/2008 - 10/2008 & 1/2009 – 4/2009		

Tag # 6L25 (CoP) Residential Health & Safety (Family Living)	Scope and Severity Rating: F		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services** (1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has: (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence; (b) General-purpose first aid kit; (c) When applicable due to an individual's health status, a blood borne pathogens kit; (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats; (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone; (f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift; (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.	Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 4 of 4 Family Living residences. The following items were not found, not functioning or incomplete: • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#2) • 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) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#2)		

Date: March 2, 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: Southwest / Southeast
Survey Date: November 30 December 1, 2009
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Family Living)
Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Ms. Kalter,

Your request for a Reconsideration of Findings was received on February 17, 2010. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A20

Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, and internal training field tools all missing trainings for the following were requested of your agency via the training checklist and signed for by C. Kalter on 12/2/09 and M. Barela on 12/1/09:

- Pre-Service (DSP #51)
- Basic Health/Orientation (DSP #51)
- First Aid (DSP #40, 41, 45, 46)
- CPR (DSP #46, 48)

The remaining citations noted in this tag 1A20 were not disputed. The scope and severity rating will remain "E."

Regarding Tag # 6L14
Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, and a review of residential record review field tools, missing documents were requested of staff in the homes. Following is a list of disputed deficiencies, requests of staff and whose signature was present on each review tool signifying they were unable to find it either:

- Individual #1 – sign by Colleen Widener on 12/3/09 no time noted
- Individual #2 – sign by Maria Allen no time noted
- Individual #3 – sign by Anne Osborn no time noted
- Individual #4 – sign by Alice Harrison 12/3/09 at 3:00PM

The remaining citations noted in tag 6L14 were not disputed. The scope and severity rating for this tag will remain "F."

Regarding Tag # 1A26
Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied and the document request form, the documentation was requested from your agency and signed for by M. Barela on 12/1/09 and C. Kalter on 12/2/09. The remaining citations noted in this tag 1A26 were not disputed. The scope and severity rating will remain "E."

Regarding Tag # 6L17
Determination: The IRF committee is modifying the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, deficiencies noted were for Individual #4. This should be addressed and submitted through the in your Plan of Correction process. The scope and severity rating will remain "A."

Regarding Tag # 6L13
Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, the information supplied for Individual #4 does not fulfill the requirements to modify or remove the deficiency. The document supplied was not evidence of a medication review, but a nursing report. Documents were requested for Individual #1, which are required per the Individual's ISP were asked for and signed by C. Kalter on 12/2/09. The scope and severity rating will remain "E."

Regarding Tag # 6L06
Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied and review of the document request form the Annual FL Home Study for Individual #2 as well as contracts for Individuals #1, 2, 3 and 4 were requested and signed for by C. Kalter on 12/2/09. Your dispute over the need for an end-date for a sub-contractor's contract with your Agency is incorrect. According to the Provider Enrollment Unit of DDSD a FL subcontract must contain an end-date. The scope and severity rating will remain "E."

Regarding Tag # 1A12
Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied and review of the Administrative Needs List, the documents were requested; "11. Copy of remittance records and supporting documentation for the month of August, September & October 2009…" Supporting documents requested and signed for by M. Barela, SC on 11/30/09. Information was not supplied to the survey team by the exit meeting. The scope and severity rating will remain "C."

Regarding Tag # 1A09.1
Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on Medication Administration Records supplied, Levothyroid for Individual #3 is "Cholesterol lowering agent," however Physician's Order state Levothyroid is to be used for "Thyroid Supplement." The remaining citations noted in tag 1A09.1 were not disputed. The scope and severity rating will remain "E."

Regarding Tag # 1A08
Determination: The IRF committee is modifying the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, and a review of the document request forms; the documents in question were requested from your agency on 12/1/09 signed by MB and 12/2/09 by C. Kalter. Citations for Individual #4 (ISP Teaching and Support Strategies and ISP Signature Page [only]) will be removed. The remaining citations noted in tag 1A08 were not disputed. The scope and severity rating will remain "B."

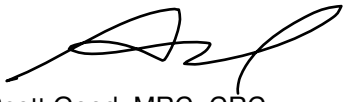
Regarding Tag # 1A05
Determination: The IRF committee is removing the original finding in the report. Based on documentation supplied it is apparent your internal policies are reviewed and signed on a yearly basis. The scope and severity rating will be changed from "F" to "not –applicable."

Regarding Tag # 1A03
Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, your agency's CQI system is still missing crucial components to assure quality. Comments such as "our process is not 100%," and "…we don't follow up…," "we look at trends informally. We do not keep minutes and do not have a formal committee;" made by you during the on-site survey and the overall amount of deficiencies found during the survey also lead to the conclusion your agency's CQI plan is non-functional. The scope and severity rating will remain "C."

This concludes the Informal Reconsideration of Finding process. The IRF process is separate and apart from the Informal Dispute Resolution process or the Medicaid Fair Hearing process when DOH sanctions are imposed on a provider.

Thank you.

Respectfully,



Scott Good, MRC, CRC
Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair

CC:
File
DHI
DDSD