Date:	September 3, 2008
To:	Ray V. Chavez, Executive Director
Provider:	Nezzy Care
Address:	904 W. Palmer
State/Zip:	Las Cruces, NM 88005
Region:	Southwest
Survey Date:	August 5 - 7, 2008
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Community Living (Family Living)
Survey Type:	Initial
Team Leader:	Crystal Lopez, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Valerie V. Valdez, MS, Health Program Manager, Division of Health Improvement/Quality Management Bureau
Survey #:	Q09.01.52981878.SW.001.INT.01

Dear Mr. Chavez,

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 is pleased to grant your new agency a "PROVISIONAL" certification for compliance with DDSD Standards and regulations.

QMB will conduct an additional annual review prior to the end of your current provider agreement. The outcome of that review will be used in determining future DHI certifications.

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 900 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 #900
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 505-222-6625, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Crystal Lopez, BA
Team Lead/Health Care Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	August 5, 2008
Present:	**Nezzy Care** Ray V. Chavez, Owner/Director/Service Coordinator Vanessa Tarango, Office Manager **DOH/DHI/QMB** Crystal Lopez, BA, Health Care Surveyor Valerie V. Valdez, MS, Health Program Manager
Exit Conference Date:	August 7, 2008
Present:	**Nezzy Care** Ray V. Chavez, Owner/Director/Service Coordinator Vanessa Tarango, Office Manager **DOH/DHI/QMB** Crystal Lopez, BA, Health Care Surveyor Valerie V. Valdez, MS, Health Program Manager **DDSD Southwest Regional Office** Zack Robinson, Social & Community Services Coordinator
Homes Visited	**Number: 5**
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 5
Persons Served Interviewed	Number: 2
Persons Served Observed	Number: 3 (one individual chose not to participate in the interview and the other two were not home at the time of the site visit)
Records Reviewed (Persons Served)	Number: 5
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 505-222-8624.
- Within 10 business days of the date you received your POC, 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 (505-841-5815), 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 505-222-8624 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, 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		
SEVERITY			**Isolated 01% - 15%**	**Pattern 16% - 79%**	**Widespread 80% - 100%**
	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.

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) 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: **Nezzy Care - Southwest Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Family Living)
Monitoring Type: Initial
Date of Survey: **August 5 - 8, 2008**

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;	Based on record review, the Agency failed to develop and implement a Continuous Quality Management System. The copy of the Agency's Continuous Quality Improvement Plan provided by the agency did not contain all components required by DD Waiver Standards. The Agency's CQI Plan did not contain the following components: (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		

(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.			

Tag # 1A07 SSI Payments	Scope and Severity Rating: C		
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. C. Provider Agency Financial Records and Accounting: Each individual served will be presumed able to manage his or her own funds unless the ISP documents justified limitations or supports for self-management, and where appropriate, reflects a plan to increase this skill. All Provider Agencies shall maintain and enforce written policies and procedures regarding the use of the individual's SSI payments or other personal funds, including accounting for all spending by the Provider Agency, and outlining protocols for fulfilling the responsibilities as representative payee if the agency is so designated for an individual.	Based on record review, the Agency failed to maintain and enforce written policies and procedures regarding the use of individuals' SSI payments or other personal funds. At the time of the review, the agency was not rep payee for any of the individuals served. However, the agency failed to maintain written policies and procedures regarding the use of individuals' SSI payments or other personal funds for future clients.		

Tag # 1A08 Agency Case File	Scope and Severity Rating: C		
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	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 5 of 5 individuals. Review of the Agency individual case files indicated the following items were missing, incomplete, and/or not current: • Current Emergency & Personal Identification Information (#1, 2, 3, 4 & 5) • Addendum A (#4 & 5) • Positive Behavioral Plan (#4 & 5) • Positive Behavioral Crisis Plan (#5) • Speech Therapy Plan (#1, 2 & 4) • Occupational Therapy Plan (#4) • Physical Therapy Plan (#4)		

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

Tag # 1A09 Medication Delivery - Physician Orders	Scope and Severity Rating: C		
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. (1) All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals shall be licensed by the Board of Pharmacy, per current 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;	Based on record review the Agency failed to provide physician's orders for 5 of 5 individuals (Individual #1, 2, 3, 4 & 5). Verbal and written requests were made during the on-site week of August 5, 2008. As of August 8, 2008 no physician's orders were provided.		

(d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. **CHAPTER 1. V. DEPARTMENT OF HEALTH INSPECTIONS AND SANCTIONS FOR NON-COMPLIANCE** A. Quality Assurance Reviews: All Provider Agencies shall permit the DOH to review the quality of care and services in accordance with Quality Management System and Review Requirements for Provider Agencies of Community-Based Services (7.14.2 NMAC). B. On-Site Inspections: All Provider Agencies shall submit to and cooperate with announced and unannounced inspection or survey and complaint investigations conducted by the DOH in order to receive or maintain a DDSD Waiver agreement and/or a contract with the DOH. The Provider Agency shall give the DOH immediate or reasonable access to all records required by these standards. The Provider Agency shall permit the DOH to have private interviews with individuals and staff.			

Tag # 1A09 Medication Delivery	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. (1) All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals shall be licensed by the Board of Pharmacy, per current 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;	Medication Administration Records (MARs) were reviewed for the months of March, April, May & June 2008 for 5 of 5 individuals. The following MARs contained missing medication entries and/or other errors: Individual #1 June 2008 MAR did not indicate the diagnosis for which the medications were prescribed, and the method of administration: • Zoloft 150mg • Tegretol 200mg • Actos 15mg • Klonopin 1mg • Invega 9mg • Trazodone 100mg • Tylenol MAR did not indicate the prescribed dosage of the following medications: • Tylenol MAR contained missing entries. No documentation found indicating reason for missing entries: • Klonopin 1mg - (One Time Daily) - Blank 6/17/2008. • Tylenol - (One Time Daily) - Blank June 17, 29 & 30, 2008. During on-site home visit on (08/06/2008) an observation of Individual #1's PRN Medication found the following was not listed on the MAR. The MAR additionally did not include an explanation for the use of the PRN medication including observable signs/symptoms or circumstances in which the medication is to be used, and documentation		

(e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (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;	of effectiveness: • Clonazepam 1mg Individual #2 Requests for April, May & June 2008 MARs were made during the on-site week of August 5, 2008. As of August 8, 2008 no MARs were provided. During on-site home visit on (08/06/2008) an observation of Individual #2's PRN Medication found the following was not listed on the MAR. The MAR additionally did not include an explanation for the use of the PRN medication including observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness: • Acetaminophen 500mg Individual #3 Requests for April, May & June 2008 MARs were made during the on-site week of August 5, 2008. As of August 8, 2008 no MARs were provided. Individual #4 May 2008 MAR for Aviane and Abilify did not contain the name of the Individual. MAR did not contain a signature page with the Initials of the individual administering or assisting with the medication: • Aviane 0.05mg • Abilify 10mg MAR did not indicate the diagnosis for which the medications were prescribed, and the frequency and method of administration for: • Aviane 0.05mg		

	• Abilify 10mg MAR contained missing entries. No documentation found indicating reason for missing entries: • Abilify 10mg - May 13, 14, 15, 16, 17, 18, 19 & 20, 2008. June 2008 MAR for Aviane and Abilify did not contain the name of the individual. MAR did not contain the Initials of the individual administering or assisting with the medication: • Aviane 0.05mg • Abilify 10mg MAR did not indicate the diagnosis for which the medications were prescribed, and the frequency and method of administration for: • Aviane 0.05mg • Abilify 10mg MAR contained missing entries. No documentation found indicating reason for missing entries: • Abilify 10mg - June 26, 27, 28, 29 & 30, 2008. • Aviane 0.05mg - June 9, 10, 11, 12, 13, 14, 26, 27, 28, 29 & 30, 2008. MAR did not indicate the prescribed dosage of the following medications: • Aviane • Abilify Individual #5 April 2008 MAR did not indicate the diagnosis for which the medications were prescribed, and the		

	frequency and method of administration for: • Carbamazepine 200mg • Fluoxetine 10mg • Amlodipine 40mg • Avelox 400mg May 2008 MAR did not indicate the diagnosis for which the medications were prescribed, and the frequency and method of administration for: • Carbamazepine 200mg • Fluoxetine 10mg • Amlodipine 40mg June 2008 MAR did not indicate the diagnosis for which the medications were prescribed, and the frequency and method of administration for: • Carbamazepine 200mg • Fluoxetine 10mg • Amlodipine 40mg		

Tag # 1A11 (CoP) Transportation	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. **G. Transportation:** Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety". The policy and procedures must address at least the following topics: (1) Drivers' requirements, (2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions, (3) Vehicle maintenance and safety inspections, (4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures, (5) Emergency Plans, including vehicle evacuation techniques, (6) Documentation, and (7) Accident Procedures.	Based on interview, the Agency failed to have a written policy and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals. When the agency Service Coordinator/Director (#11) was asked if the Agency had a policy regarding the safe transportation of individuals, #11 stated, "We have no formal policy on Transportation, but does have a recommendation that all my providers should get some type of defensive driving training, along with training on safety and lifting. We do not provide any transportation training." When Family Living Providers were asked if they received transportation training 5 of 5 FLP reported not receiving transportation training. (#6, 7, 8, 9 & 10)		

Tag # 1A15 Nurse Availability	Scope and Severity Rating: F		
Developmental Disabilities (DD) Waiver Service Standards 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.	Based on record review and interview the Agency failed to ensure proper nursing oversight and availability of nursing. Review of Agency's policy and procedure did not indicate how nursing services were to be made available to clients. When asked, the following was reported by agency staff: • Service Coordinator #11 reported, "Family Living Providers don't have a number to reach the nurse directly, but they would call me and I would call the on-call nurse at one of the nursing agencies that Nezzy Care contracts with." • FLP #6 reported, "I would call the office or call the Director's (#11) cell phone so they could call the nurse." • FLP #7 reported, "I have no numbers to reach the agency nurse." • FLP #8 reported, "I don't know. I guess I would call La Clínica de Familia." • FLP #9 reported, "I have no way to reach an agency nurse." • FLP #10 reported, "Nezzy Care's nursing is through Coordinated Care. To reach them I would call Ray or use the phonebook to find their number."		

Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: F		

Developmental Disabilities (DD) Waiver Service Standards 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.
(1) Documentation of nursing assessment activities
(a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training:
(i) Community living services provider agency;
(ii) Private duty nursing provider agency;
(iii) Adult habilitation provider agency;
(iv) Community access provider agency; and
(v) Supported employment provider agency.
(b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT
	Based on record review the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 5 of 5 individuals.
	
	The following were missing, not current or incomplete:
	
	• Medication Administration Assessment Tool (#1)
	
	• Crisis Plans
	  • Cardiac Condition (#2)
	  • Diabetes (#4)
	  • Seizures (#5)
	
	• Health Assessment Tool (#1, 2, 3, 4 & 5)
	
	Upon record review, it could not be determined if Health Care Plans were required for 5 of 5 individuals because the HAT was missing or incomplete.		

instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request. (c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first. (d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy). (e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as *subjective* information including the individual complaints, signs and symptoms noted by staff, family members or other team members; *objective* information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants. **(2) Health related plans**			

(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional. (b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan. (c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. (d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings. **(3)** For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended): (a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition. (b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the			

goal. (c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan. (d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions. (e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings. (f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization. (g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author. (h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed. **(4) General Nursing Documentation** (a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be			

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

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C**. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 4 of 5 Family Living Providers. Review of Family Living Provider training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (#6) • Basic Health/Orientation (#6 & 7) • Person-Centered Planning (1-Day) (#7 & 10) • CPR (#7) • Assisting With Medications (#7 & 8)		

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 Governing the Training Requirements for Direct Support Staff and	Based on interview, the Agency failed to ensure that training competencies were met for 3 of 5 Family Living Providers (FLP). When FLP were asked if they assisted the individual with medications and if they had completed Assisting with Medication (AWM) training, the following was reported: • FLP #6 reported (via translator, i.e. Service Coordinator/Director #11), "I do administer medications but have not received the Assisting with Medications training." • FLP #7 reported, "I do prompt and assist Individual #2 in taking her medications but never had the Assisting with Medications training." When FLP were asked what steps were they to take in the event of a medication error, for example dropping a medication, the following was reported: • FLP # 6 reported (via translator, i.e. Service Coordinator/Director #11), "since my daughter takes controlled substances they are very closely monitored and I am very careful. But if I did drop a medication I would probably pick it up and give it to her, but I know I should throw it away." (Individual #1) • FLP #7 reported, "I would I throw it away and get another one." (Individual #2) • FLP #8 reported, "The pill would be contaminated so I would flush it down the toilet or sink and give her another one." (Individual #3) Per Agency policy "all medication errors or incidents will be documented on an internal incident report form. Medication errors will be addressed immediately. The staff will follow up on all medication incidents/errors within 24		

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.	hours. The staff member will take appropriate action to avoid medication errors or medication incidents. The staff members' supervisor will forward the incident report form to the agency nurse, along with a summary of his/her actions within 48 hours. A Medication Incident is defined as, but not limited to: Person refuses to take medication, medication package does not match medication, MAR does not match medication or medication package, medication is dropped or contaminated, person who self administer his/her medication misses a dosage of medication, medication pack is no in the house, medication is given, but staff have failed to initial the MAR or have made a documentation error, medication is missed due to an error on the individual's part, a potential side effect is noted. All unused, contaminated, and discontinued medications will be stored in a sealed bag or container in the individuals locked box or cabinet until taken to administration for proper disposal" When FLP were asked to describe the signs of an allergic reaction to food, the following was reported: • FLP #8 reported, "I don't know because I have never been in that situation." When FLP were asked to describe the signs of an adverse drug reaction, the following was reported: • FLP #8 reported, "Her eyes would roll back into her head and she would slur her words."		

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: E		
NMAC 7.1.9.9 **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11** **DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection. **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.	Based on record review, the Agency failed to maintain documentation indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 2 of 5 Agency Personnel. • #6 - Date of hire 06/25/08 • #10 - Date of hire 05/13/08		

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: F		
NMAC 7.1.13.10 **INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.	Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 6 of 6 Agency Personnel. • Abuse, Neglect & Exploitation (#6, 7, 8, 9, 10 & 11)		

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: F		
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 or exploitation for 5 of 5 individuals. • Parent/Guardian Abuse, Neglect & Exploitation Training (#1, 2, 3, 4 & 5)		

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: F		
NMAC 7.1.13.10 **INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **F. Posting of Incident Management Information Poster:** All licensed health care facilities and community based service providers shall post two (2) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. All licensed health care facilities and community based service providers operating sixty (60) or more beds shall post three (3) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. The posters shall be posted where employees report each day and from which the employees operate to carry out their activities. Each licensed health care facility or community based service provider shall take steps to insure that the notices are not altered, defaced, removed, or covered by other material. [7.1.13.10 NMAC - N, 02/28/06]	Based on observation, the Agency failed to post two (2) or more Incident Management Information posters in a prominent public location for 5 of 6 locations. Administrative Location: • Home Office Residence of : • Individual #2 • Individual #3 • Individual #4 • Individual #5		

Tag # 1A29 Complaints / Grievances	Scope and Severity Rating: C		
NMAC 7.26.3.6 A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's complaint or grievance procedure	Based on record review, the Agency failed to provide documentation that the complaint procedure had been made available to individuals or their legal guardians for 5 of 5 individuals. • Grievance/Compliant Procedure (#1, 2, 3, 4 & 5)		

Tag # 1A31 (CoP) Client Rights	Scope and Severity Rating: F		
NMAC 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]. 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] **DDSD Policy - Human Ri**ghts Committee Requirements eff**ective 3/1/2003** **IV. POLICY STATEMENT:** Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans. **A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS**: **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.	Based on record review and interview the Agency failed to adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. Record review indicated 3 of 5 individuals required positive behavior support plans. No positive behavior support plans were found for 3 of 3 to verify if HRC approval was needed for. (Individuals #1, 4 & 5) Record review of the Agency's policies and procedures found no evidence indicating the Agency had a Human Rights Committee. When surveyors asked the Service Coordinator/Director (#11) to provide Human Rights Committee meeting minutes, #11 stated, "The agency was not part of a Human Rights Committee at this time."		

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: F		
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 5 of 5 individuals. Per Individuals ISP's the following was found with regards to the implementation of ISP Outcomes: Community Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes: • Outcomes and action plans listed on daily progress notes did not match ISP (Individuals #1, 2 & 4) • None found for 5/1/08 - 6/30/08 (Individual #3) • None Found for 4/01/08 - 6/30/08 (Individual #5)		

Tag # 1A33 Board of Pharmacy - Med Storage	Scope and Severity Rating: E		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **E. Medication Storage:** 1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee. 2. Drugs to be taken by mouth will be separate from all other dosage forms. 3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature. 4. Separate compartments are required for each resident's medication. 5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day. 6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist.	Based on record review and observation, the Agency failed to ensure proper storage of medication for 4 of 5 individuals. Review of the Agency's policy stated, "Medications stored in an individual's home will be kept in a locked box or cabinet separated by the person. Each individual will have their own locked box. The box or cabinet will be secured with either a key lock or a combination lock. If the medications require refrigeration, a locked compartment will be placed in the individual's refrigerator." During site visits on 08/05/08, surveyors found the policy was not being followed. Observation included: Individual #1 • Medications were not kept in a lock box. Medications were kept in a cabinet in the kitchen where the individual had access to their medications. Individual #2 • Medications were not kept in a lock box. Medications were kept in the kitchen where the individual had access to their medications Individual #3 • Medications were not kept in a lock box. Medications were kept where the individual had access to their medications Individual #5 • Medications were not kept in a lock box. Medications were kept where the individual had access to their medications.		

Tag # 1A36 SC Training	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C**. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training **Requirements for** Direct Support Staff and **Internal Service Coordinators** Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 1 Service Coordinators. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed: • Pre-Service Manual (SC #11) • Person Centered Planning (2-Day) (SC #11) • Promoting Effective Teamwork (SC #11)		

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: F		
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.	Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 6 of 6 Agency Personnel. • Individual Specific Training (#6, 7, 8, 9, 10 & 11)		

Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: B		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007CHAPTER 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.	Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 3 of 5 individuals. • DDSD Approval for Subcontractor (#2) • Current Family Living Contract (#1 & 4)		

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: F		
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	Based on record review, the Agency failed to provide documentation of an annual exam and/or other examinations as specified by a licensed physician for 5 of 5 individuals. • Annual Physical (#5) • Dental Exam (#2, 3, 4 & 5) • Auditory Exam (#1, 2, 3, 4 & 5) • Vision Exam (#1, 2, 3, 4 & 5) • Psychotropic Medication Review (#3 & 5) • Blood Levels (#1, 2, 3 & 5)		

Nursing Services. b) That each individual with a score of 4, 5, or 6 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: C		

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
	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 5 of 5 Individuals receiving Family Living Services or Supported Living Services.
	• Current Emergency & Personal Identification (#2, 4 & 5)
	• Annual ISP (#3)
	• ISP Signature Page (#2 & 3)
	• Addendum A (#1, 2, 3, 4 & 5)
	• Individual Specific Training (Addendum B) (#3)
	• Positive Behavioral Plan (#1, 3, 4 & 5)
	• Speech Therapy Plan (#1, 2 & 4)
	• Occupational Therapy Plan (#1, 4 & 5)
	• Physical Therapy Plan (#1, 4 & 5)
	• Special Health Care Needs
	  • Nutritional Plan (#4)
	• Health Assessment Tool (#1, 2, 3, 4 & 5)
	• Crisis Plan
	  • Seizures (#5)
	  • Diabetes (#1 & 4)
	• Progress Notes/Daily Contacts Logs (#3)
	• Data Collection/Data Tracking (#3, 4 & 5)
	• Progress Notes written by DSP and/or		

response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of a physician's or qualified health care provider's 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	Nurses regarding individual health status and physical conditions including action taken (#3) • Health Care Providers Written Orders (#1, 2, 3, 4 & 5) • Abnormal Involuntary Movement Screening (#3) • Medication Administration Record (MAR) (#3)		

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

Tag # 6L17 Reporting Requirements	Scope and Severity Rating: B		
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 3 of 5 individuals receiving Community Living Services. Community Living Quarterly Reports • Individual #2- None found from 03/2008 – 08/2008 • Individual #3 - None found from 03/2008 – 08/2008. • Individual #5 – None found from 03/2008 – 08/2008		

Tag # 6L25 (CoP) Residential Reqts.	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 5 of 5 Supported Living and Family Living residences. The following items were missing, not functioning or incomplete: • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#1, 2, 3, 4 & 5) • Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#4 & 5) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#1, 2, 3, 4 & 5) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 2, 3, 4 & 5)		

ADDITIONAL FINDINGS: Reimbursement Deficiencies

BILLING
TAG #1A12

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 Chapter 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION

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.

Billing for Community Living (Family Living) service was reviewed for 5 individuals. Progress notes and billing records supported billing activities for the months of April, May and June 2008.