

Date: November 19, 2013

To: Christine Chapman, Executive Director
Provider: Safe Harbor, Inc.
Address: 506 S. Main Ste 908
State/Zip: Las Cruces, New Mexico 88001
E-mail Address: garychpm@aol.com

CC: Bonnie Chapman, Assistant Director
Address: 506 S. Main Ste 908
State/Zip: Las Cruces, New Mexico 88001
E-mail Address: bonbonexpress@yahoo.com

Region: Southwest
Routine Survey: February 18 - 21, 2013
Verification Survey: November 18 - 19, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living) and Community Inclusion Supports (Adult Habilitation)

Survey Type: Verification
Team Leader: Valerie V. Valdez, MS, Health Program Manager, Division of Health Improvement/Quality Management Bureau
Team Members: Amanda Castaneda, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Chapman;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on February 18 - 21, 2013*.

The Division of Health Improvement, Quality Management Bureau has determined your agency is now in:

Compliance with Conditions of Participation

However due to the new/repeat deficiencies your report of findings will be referred to the Internal Review Committee (IRC) for further action and potential sanctions. You will be contacted by the IRC for instructions on how to proceed. Please call the Plan of Correction Coordinator at 505-699-9356, if you have questions about the survey or the report.

Thank you for your cooperation and for the work you perform.

Sincerely,

Valerie V. Valdez, MS

Valerie V. Valdez
Team Lead/Health Program Manager
Division of Health Improvement
Quality Management Bureau



DIVISION OF HEALTH IMPROVEMENT
5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108
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QMB Report of Findings – Safe Harbor, Inc. – Southwest Region – November 18 – 19, 2013

Survey Process Employed:

Entrance Conference Date: November 18, 2013

Present:

Safe Harbor, Inc.

Wendy Horton, Research Associate
Christine Chapman, Executive Director
Sarah Lockyear, Service Coordinator

DOH/DHI/QMB

Valerie V. Valdez, MS, Team Lead/Health Program Manager
Amanda Castaneda, MPA, Healthcare Surveyor

Exit Conference Date: November 19, 2013

Present:

Safe Harbor, Inc.

Christine Chapman, Executive Director
Bonnie Chapman, Assistant Director
Sarah Lockyear, Service Coordinator
Wendy Horton, Research Associate
Victoria Holloway, Office Manager

DOH/DHI/QMB

Valerie V. Valdez, MS, Team Lead/Health Program Manager
Amanda Castaneda, MPA, Healthcare Surveyor

DDSD - SW Regional Office

None – Informed Regional office prior to exit

Administrative Locations Visited Number: 1

Total Sample Size Number: 7
1 - Jackson Class Members
6 - Non-Jackson Class Members
6 - Supported Living
7 - Adult Habilitation

Total Homes Visited Number: 3

❖ Supported Living Homes Visited Number: 3

Persons Served Records Reviewed Number: 7

Direct Support Personnel Interviewed Number: 5

Direct Support Personnel Records Reviewed Number: 27

Service Coordinator Records Reviewed Number: 2

Administrative Processes and Records Reviewed:

- Individual Medical and Program Case Files, including, but not limited to:
 - Individual Service Plans
 - Progress on Identified Outcomes
 - Healthcare Plans
 - Medication Administration Records
 - Medical Emergency Response Plans

QMB Report of Findings – Safe Harbor, Inc. – Southwest Region – November 18 – 19, 2013

Survey Report #: Q.14.2.DDW.79902782.3.001.VER.01.323

- Therapy Evaluations and Plans
- Healthcare Documentation Regarding Appointments and Required Follow-Up
- Other Required Health Information
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Quality Assurance / Improvement Plan

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

Attachment B

Department of Health, Division of Health Improvement QMB Determination of Compliance Process

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and state and federal regulations. QMB has grouped the CMS assurances into five Service Domains: Level of Care; Plan of Care; Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Management system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified in the QMB Report of Findings. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

Within the QMB Service Domains there are fundamental regulations, standards, or policies with which a provider must be in essential compliance in order to ensure the health and welfare of individuals served known as Conditions of Participation (CoPs).

The Determination of Compliance for each service type is based on a provider's compliance with CoPs in three (3) Service Domains.

Case Management Services:

- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

- Qualified Provider
- Plan of Care
- Health, Welfare and Safety

Conditions of Participation (CoPs)

A CoP is an identified fundamental regulation, standard, or policy with which a provider must be in compliance in order to ensure the health and welfare of individuals served. CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances. A provider must be in compliance with CoPs to participate as a waiver provider.

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP. (See the next section for a list of CoPs.) The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team's analysis establishes that there is an identified

potential for significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

The Division of Health Improvement (DHI) and the Developmental Disabilities Supports Division (DDSD) collaborated to revise the current Conditions of Participation (CoPs). There are seven Conditions of Participation in which providers must be in compliance.

CoPs and Service Domains for Case Management Supports are as follows:

Service Domain: Level of Care

Condition of Participation:

1. **Level of Care:** The Case Manager shall complete all required elements of the Long Term Care Assessment Abstract (LTCAA) to ensure ongoing eligibility for waiver services.

Service Domain: Plan of Care

Condition of Participation:

2. **Individual Service Plan (ISP) Creation and Development:** Each individual shall have an ISP. The ISP shall be developed in accordance with DDSD regulations and standards and is updated at least annually or when warranted by changes in the individual's needs.

Condition of Participation:

3. **ISP Monitoring and Evaluation:** The Case Manager shall ensure the health and welfare of the individual through monitoring the implementation of ISP desired outcomes.

CoPs and Service Domain for ALL Service Providers is as follows:

Service Domain: Qualified Providers

Condition of Participation:

4. **Qualified Providers:** Agencies shall ensure support staff has completed criminal background screening and all mandated trainings as required by the DDSD.

CoPs and Service Domains for Living Supports and Inclusion Supports are as follows:

Service Domain: Plan of Care

Condition of Participation:

5. **ISP Implementation:** Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.

Service Domain: Health, Welfare and Safety

Condition of Participation:

6. **Individual Health, Safety and Welfare: (Safety)** Individuals have the right to live and work in a safe environment.

Condition of Participation:

7. **Individual Health, Safety and Welfare (Healthcare Oversight):** The provider shall support individuals to access needed healthcare services in a timely manner. Nursing, healthcare services and healthcare oversight shall be available and provided as needed to address individuals' health, safety and welfare.

QMB Determinations of Compliance

Compliance with Conditions of Participation

The QMB determination of *Compliance with Conditions of Participation* indicates that a provider is in compliance with all Conditions of Participation, (CoP). The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation in all relevant Service Domains. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) out of compliance in any of the Service Domains.

Partial-Compliance with Conditions of Participation

The QMB determination of *Partial-Compliance with Conditions of Participation* indicates that a provider is out of compliance with Conditions of Participation in one (1) to two (2) Service Domains. The agency may have one or more Condition level tags within a Service Domain. This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains.

Providers receiving a repeat determination of Partial-Compliance for repeat deficiencies at the level of a Condition in any Service Domain may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

Non-Compliance with Conditions of Participation

The QMB determination of *Non-Compliance with Conditions of Participation* indicates a provider is significantly out of compliance with Conditions of Participation in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains

Providers receiving a repeat determination of Non-Compliance will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

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

Introduction:

Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated “Document Request,” or “Administrative Needs,” etc. forms. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: <http://dhi.health.state.nm.us/qmb>
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRF process, email the IRF Chairperson, Crystal Lopez-Beck at crystal.lopez-beck@state.nm.us for assistance.

The following limitations apply to the IRF process:

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

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

The IRF Committee will review the request, the Provider will be notified in writing of the ruling; no face-to-face meeting will be conducted.

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

Agency: Safe Harbor, Inc. - Southwest Region
Program: Developmental Disabilities Waiver
Service: Community Living Supports (Supported Living) and Community Inclusion Supports (Adult Habilitation)
Monitoring Type: Verification Survey
Routine Survey: February 18 - 21, 2013
Verification Survey: November 18 - 19, 2013

Standard of Care	Routine Survey Deficiencies February 18 - 21, 2013	Verification Survey New and Repeat Deficiencies November 18 - 19, 2013
Service Domain: Service Plans: ISP Implementation – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.		
Tag # 1A32 and 6L14 Individual Service Plan Implementation	Condition of Participation Level Deficiency	Standard Level Deficiency
<p>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the</p>	<p>After an analysis of the evidence it has been determined that there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 7 of 7 individuals.</p> <p>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Administrative Files Reviewed:</p> <p>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #2</p> <ul style="list-style-type: none"> • None found for 12/2012 - 1/2013. <p>Individual #4</p>	<p>New / Repeat Finding:</p> <p>Based on record review, the Agency did not 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 7 individuals.</p> <p>Per Individuals' ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Administrative Files Reviewed:</p> <p>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #1</p> <ul style="list-style-type: none"> • Per Work/Education/Volunteer Outcome; Action Step for "...will be transported to her mani/pedi group with Kindle in hand" is to be completed 1 time per week evidence found indicated it was not being completed at the required frequency as

<p>developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<ul style="list-style-type: none"> • None found regarding Live Outcome: "Once ... is able to complete step one, she will then take three trips out of Las Cruces with minimal behaviors rest of the week" for 11/2012 - 12/2012 • Per Live Outcome "...will be able to tolerate 3 out of town trips." Action Steps for "once (#4) is able to complete step one, she will then take three trips out of Las Cruces with minimal behaviors rest of the week," is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2013. • Per Health Outcome "...will exercise daily." Action Steps for "exercises daily" is to be completed 1 time per day. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2012 and 1/2013. • "...will pick the holidays she would like to celebrate bi-weekly," is to be completed bi-weekly. Action Step was not being completed at the required frequency for 1/2013. <p>Individual #5</p> <ul style="list-style-type: none"> • Per Live Outcome "I will decorate my home once a month with different homemade decorations." Action Step for "will create decorations" is to be completed 2 - 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2012; 12/2012. • Per Fun Outcome "...will access applications of her own choice without assistance." Action Step for "will practice an electronic tablet for 20 	<p>indicated in the ISP for 9/2013 – 10/2013.</p> <ul style="list-style-type: none"> • Per Work/Education/Volunteer Outcome; Action Step for "...will be given a choice of a game or music to engage in on her Kindle" is to be completed 1 time per week evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2013 – 10/2013. • Per Work/Education/Volunteer Outcome; Action Step for "during the waiting period for her mani/pedi...will engage in her selected activity of choice (game or music) with another individual using her Kindle" is to be completed 1 time per week evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2013 – 10/2013.
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	<p>minutes” is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2012; 12/2012.</p> <ul style="list-style-type: none"> • Per Fun Outcome "I will create a photo journal of her life experiences and share it with others." Action Step for “work on the journal” is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2012; 12/2012. • January 2013: None found regarding Action Step for “...will create decorations.” • January 2013: None found regarding Action Step for “...will practice an electronic tablet for 20 minutes.” • January 2013: None found regarding Action Step for “...work on the journal.” <p>Individual #6</p> <ul style="list-style-type: none"> • None found for 11/2012 - 1/2013. <p>Individual #7</p> <ul style="list-style-type: none"> • None found for 12/2012 – 1/2013. <p>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #1</p> <ul style="list-style-type: none"> • None found for 11/2012. <p>Individual #2</p> <ul style="list-style-type: none"> • No Outcomes or DDSD exemption/decision justification found for Adult Habilitation Services. As indicated by NMAC 7.26.5.14 “Outcomes are 	
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required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.”

Individual #4

- None found regarding "Research activities she would like to try bi-weekly" for 11/2012.
- None found regarding "Pick favorite event and attend 20 events" for 11/2012; 12/2012.
- None found regarding "Attempt 3 local outings with minimal behaviors the rest of the week" for 11/2012; 12/2012
- Per Work/Learn Outcome "...will prepare a dish for the pot luck." Action Steps for "completes one dish for the potluck party" is to be completed biweekly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2012; 12/2012.
- "...will make 24 birthday cards" is to be completed bi-weekly. Action Step was not being completed at the required frequency for 1/2013.

Individual #5

- No Outcomes or DDSD exemption/decision justification found for Adult Habilitation Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.”

Individual #6

- None found for 1/2013.

Individual #7

- None found for 12/2012 - 1/2013.

Residential Files Reviewed:

Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

Individual #2

- None found for 2/1/2013 – 2/19/2013.

Individual #3

- “...will plan the visit” is to be completed 1 time per week. Action Step was not being completed at the required frequency for 2/01/2013 - 2/19/2013.

Individual #5

- None found for 2/1/2013 – 2/18/2013.

Individual #6

- None found for 2/1/2013 – 2/18/2013.

Standard of Care	Routine Survey Deficiencies February 18 - 21, 2013	Verification Survey New and Repeat Deficiencies November 18 - 19, 2013
<p>Service Domain: Qualified Providers – <i>The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.</i></p>		
<p>Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry</p>	<p>NA</p>	<p>Standard Level Deficiency</p>
<p>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p>		<p>New Finding:</p> <p>Based on record review, the Agency did not maintain documentation in the employee’s personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 1 of 29 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:</p> <p>Direct Support Personnel (DSP):</p> <ul style="list-style-type: none"> • #68 – Date of hire 5/18/2013, completed 5/21/2013.

D. **Documentation of inquiry to registry.** The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.

E. **Documentation for other staff.** With respect to all employed or contracted individuals 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.

Standard of Care	Routine Survey Deficiencies February 18 - 21, 2013	Verification Survey New and Repeat Deficiencies November 18 - 19, 2013
<p>Service Domain: Health and Welfare – The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.</p>		
Tag # 1A09 Medication Delivery Routine Medication Administration	Condition of Participation Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <p>(a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Medication Administration Records (MAR) were reviewed for the months of December 2012, January and February 2013.</p> <p>Based on record review, 6 of 6 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</p> <p>Individual #2 December 2012</p> <p>Medication Administration Records indicate the following medications are both a Routine and a PRN medication. MAR indicates dosages are different, yet both medications are to be given at bedtime. MAR indicates Individual may receive both dosages in a day which concludes the Individual would receive more than the recommended dose in a 24 hour period on those days. Per PRN Medication Administration Record, Individual is not to exceed 6 Tbsp within a 24 hour period. For December 2012 the Individual exceeded the dosage 17 times in 31 days.</p> <ul style="list-style-type: none"> • Milk of Magnesia 3 Tbsp (1 time daily) – Given 	<p>New / Repeat Finding:</p> <p>Medication Administration Records (MAR) were reviewed for the months of September and October 2013.</p> <p>Based on record review, 3 of 6 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</p> <p>Individual #2 October 2013</p> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Penactin 4mg (4 times daily) – Blank 10/31 (5:30 AM) • Luminal 30mg (4 times daily) – Blank 10/12 & 31 (5:30 AM) • Keppra 500mg (1 time daily) – Blank 10/31 (5:30 AM) • Anafranil 25mg (1 time daily) – Blank 10/31 (5:30 AM) • Invega 9mg (1 time daily) – Blank 10/31 (5:30 AM)

<p>brand and generic name of the medication, diagnosis for which the medication is prescribed;</p> <p>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</p> <p>(c) Initials of the individual administering or assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including</p>	<p>12/1 – 31.</p> <ul style="list-style-type: none"> • Milk of Magnesia 4 Tbsp (PRN) - Medication was given 1 time on 12/5, 6, 7, 9, 10, 13, 15, 16, 17, 20, 21, 22, 25, 26, 27, 29, 30. <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Fiber Therapy (3 times daily) (9 AM) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Keppra 500 mg (3 times daily) (5:30 AM) • Anafri/ Clomipramine 25 mg (2 times daily) (5:30 AM) • Lactulose 15 ml (1 time daily) • Invega 9 mg (1 time daily) • Juice Plus (1 time daily) • Fiber Therapy (3 times daily) (9 AM) • Colazapine 100 mg (1 time daily) (5:30 AM) <p><i>*NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MAR for each time frame the medication is to be given and the deficiency is specific to that MAR.</i></p> <p>January 2013 Medication Administration Records indicate the following medications are both a Routine and a PRN medication. MARs indicates dosages are different, yet both medications are to be given at bedtime. MAR indicates Individual may receive</p>	<p>AM)</p> <ul style="list-style-type: none"> • Juice Plus (1 time daily) – Blank 10/31 (5:30 AM) • Periactin 4mg (4 times daily) – Blank 10/25 (12:30 PM) • Juice Plus (Red) (1 time daily) – Blank 10/23 (12:30 PM) • Clozaril 100mg (1 time daily) – Blank 10/1 (5:30 AM) <p>Individual #3 September 2013 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Miralax 3350 (2 times daily) – Blank 9/22 & 23 (7 PM) <p>Individual #7 October 2013 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Promethazine (3 times daily) <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Promethazine (3 times daily)
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<p>over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. <p>Model Custodial Procedure Manual D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> ➤ symptoms that indicate the use of the medication, ➤ exact dosage to be used, and ➤ the exact amount to be used in a 24 hour period. 	<p>both dosages in a day which would conclude the Individual would receive more than the recommended dose in a 24 hour period on those days. Per PRN Medication Administration Record, Individual is not to exceed 6 Tbsp within a 24 hour period. For January 2013 the Individual exceeded the dosage 18 times in 31 days.</p> <ul style="list-style-type: none"> • Milk of Magnesia 3 Tbsp (1 time daily) Medication was given routinely 1 time daily from January 1 – 31. • Milk of Magnesia 4 Tbsp (PRN) Medication was given 1 time on 1/2, 3, 5, 7, 8, 10, 11, 13, 14, 15, 17, 18, 22, 23, 24, 27, 30, 31. <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Fiber Therapy (3 times daily) (9 AM) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Keppra 500 mg (3 times daily) (5:30 AM) • Anafril/ Clomipramine 25 mg (2 times daily) (4 PM) • Lactulose 15 ml (1 time daily) • Invega 9 mg (1 time daily) • Juice Plus (1 time daily) • Fiber Therapy (3 times daily) (4 PM) • Colazapine 100 mg (1 time daily) <p><i>*NOTE: Deficiencies which list a specific time, is</i></p>	
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because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.

February 2013

Medication Administration Records did not contain the dosage for the following medications:

- Fiber Therapy (3 times daily)

Medication Administration Records did not contain the route of administration for the following medications:

- Anafril/ Clomipramine 25 mg (2 times daily)
- Lactulose 15 ml (1 time daily)
- Invega 9 mg (1 time daily)
- Juice Plus (1 time daily)
- Fiber Therapy (3 times daily)
- Colazapine 100 mg (1 time daily)

Individual #3

January 2013

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Aspirin 325 mg (1 time daily)

Medication Administration Records did not contain the route of administration for the following medications:

- Aspirin 325 mg (1 time daily)
- Docusate 100 mg (2 times daily) (7 PM)

**NOTE: Deficiencies which list a specific time, is*

because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.

February 2013

Medication Administration Records did not contain the strength of the medication which is to be given:

- Aspirin (1 time daily)

Individual #4

December 2012

Medication Administration Records did not contain the route of administration for the following medications:

- Lithium 300 mg (2 times daily) (8 AM)
- Loratadine 10 mg (1 time daily)
- Risperidone 2 mg (2 times daily) (2 PM)

**NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.*

January 2013

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

- Benzotropine 1 mg (2 times daily) – Blank 1/24 (8 AM)
- Venlafaxine 75 mg (1 time daily) – Blank 1/24 (8 AM)
- Lithium 300 mg (2 times daily) – Blank 1/24 (8 AM)

Medication Administration Records did not

	<p>contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Lithium 300 mg (2 times daily) (8 AM) • Loratadine 10 mg (1 time daily) • Risperidone 2 mg (2 times daily) (2 PM) <p><i>*NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.</i></p> <p>Individual #5 December 2012 Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Loratadine 10 mg (1 time daily) • Levofloxacin 500 mg (1 time daily) <p>Medication Administration Record did not contain the specific name of the medication to be given, for the following medications:</p> <ul style="list-style-type: none"> • Foot Powder (1 time daily) <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Levofloxacin 500 mg (1 time daily) <p>January 2013 Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Loratadine 10 mg (1 time daily) • Zoloft 5 mg (1 time daily) 	
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- Z-pack (1 time daily for 5 days)

Medication Administration Records did not contain the frequency of medication to be given:

- Systane Gel

February 2013

Medication Administration Records did not contain the route of administration for the following medications:

- Loratadine 10 mg (1 time daily)
- Zolof 5 mg (1 time daily)

Individual #6

December 2012

Medication Administration Records did not contain the route of administration for the following medications:

- Carbi/Levod 25/250 mg (4 times daily) (4 PM)
- Simvastatin 40 mg (1 time daily)
- Benzotropine 1 mg – (2 times daily) (8 PM)
- Benzotropine 0.5 mg – (8 PM)
- Aricept/Donepezil 10 mg – (8 PM)
- Vitamin D1000IU – (2 times daily)

**NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.*

Medication Administration Records did not contain the diagnosis for which the medication is

	<p>prescribed:</p> <ul style="list-style-type: none"> • Benzotropine 0.5 mg – (8 PM) <p><i>*NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.</i></p> <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Benzotropine 0.5 mg – (8 PM) • Aricept/Donepezil 10 mg – (8 PM) <p><i>*NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.</i></p> <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Benzotropine 0.5 – (8 PM) • Aricept/Donepezil 10 mg – (8 PM) • Vitamin D1000IU – (2 times daily) (8 AM) <p><i>*NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.</i></p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Benzotropine 0.5 mg (2 times daily) (8 PM) • Benzotropine 1 mg – (2 times daily) (8 PM) 	
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	<ul style="list-style-type: none"> • Aricept/Donepezil 10 mg – (8 PM) • Vitamin D1000IU – (2 times daily) (8 AM) <p><i>*NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.</i></p> <p>January 2013 Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Benzotropine 1 mg (8 PM) • Carbi/Levod 25/250 mg (12 PM) • Aricept/Donepezil 10 mg • Pramipexole/Mirapex 1.5 (8 PM) • Pramipexole/Mirapex 1.5 (12 PM) • Simvistatin 40 mg (2 times daily) • Vitamin D 1000IU (8AM) • Vitamin D 1000 IU (2 times daily) (8PM) <p><i>*NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.</i></p> <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Benzotropine 1 mg (8 PM) • Carbi/Levod 25/250 mg (12 PM) 	
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- Carbi/Levod 25/250 mg (4 PM)
- Aricept/Donepezil 10 mg (8 PM)
- Pramipexole/Mirapex 1.5 (12 PM)
- Vitamin D 1000IU (8AM)

**NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.*

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Benzotropine 1 mg (8 PM)
- Carbi/Levod 25/250 mg (12 PM)
- Aricept/Donepezil 10 mg (8 PM)
- Pramipexole/Mirapex 1.5 (12 PM)
- Pramipexole/Mirapex 1.5 (8 PM)
- Vitamin D 1000IU (8AM)

**NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.*

February 2013

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

- Carbi/levod 25/250 mg (4 times daily) – Blank

	<p>2/17 (4 PM)</p> <ul style="list-style-type: none"> • Pranicexole/mirapex 1.5 mg (4 times daily) – Blank 2/17 (4 PM) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Simvastitan 40mg (1 time daily) • Vitamin D 1000IU (2 times daily) • Aricept/Donepezil 10 mg – (8 PM) <p><i>*NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.</i></p> <p>As indicated by the Medication Administration Records the individual is to take Benzotropine MES .05 (half a tablet 2 times daily). According to the Individual's prescription bubble pack, Benzotropine MES .05 (1 tablet) is to be taken 2 times daily; Medication Administration Record and Bubble Pack do not match.</p> <p>Individual #7 December 2012</p> <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Cerotivite Advanced Form (1 time daily) • Senna Laxitive (2 times daily) (8 AM) <p><i>*NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.</i></p>	
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	<p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Phenytoin Extended 100 mg (1 time daily) <p>January 2013</p> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Clonazepam .5 mg (2 times daily) (8 PM) • Senna Laxative (2 times daily) (8 AM) • Fluvoxamine 100 mg (1 time daily) • Levofloxacin 500 mg (1 time daily) • Phenytoin Extended 100 mg (1 time daily) <p><i>*NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MARs for each time frame the medication is to be given and the deficiency is specific to that MAR.</i></p> <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Cerotivite Advanced Form (1 time daily) • Senna Laxative (2 times daily) (8 AM) <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Fluvoxamine 100 mg – (2 times daily) (8 PM) <p><i>*NOTE: Deficiencies which list a specific time, is because the Agency keeps a separate MARs for each time frame the medication is to be given</i></p>	
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and the deficiency is specific to that MAR.

February 2013

Medication Administration Records did not contain the strength of the medication which is to be given:

- Cerovite Advanced Form (1 time daily)
- Senna Laxative (2 times daily)

Tag # 1A09.1 Medication Delivery PRN Medication Administration	Condition of Participation Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <p>(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;</p> <p>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</p> <p>(c) Initials of the individual administering or</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Medication Administration Records (MAR) were reviewed for the months of December 2012, January and February 2013.</p> <p>Based on record review, 6 of 6 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard:</p> <p>Individual #2 December 2012 Medication Administration Records indicate the following medications are both a Routine and a PRN medication. MARs indicates dosages are different, yet both medications are to be given at bedtime. MAR indicates Individual may receive both dosages in a day which would conclude the Individual would receive more than the recommended dose in a 24 hour period on those days. Per PRN Medication Administration Record, Individual is not to exceed 6 Tbsp within a 24 hour period. For December 2012 the Individual exceeded the dosage 17 times in 31 days.</p> <ul style="list-style-type: none"> • Milk of Magnesia 3 Tbsp (1 time daily) Medication was given routinely 1 time daily from December 1 – 31. • Milk of Magnesia 4 Tbsp (PRN) – Medication was given 1 time on 12/5, 6, 7, 9, 10, 13, 15, 16, 17, 20, 21, 22, 25, 26, 27, 29, 30. <p>January 2013</p>	<p>New / Repeat Finding:</p> <p>Medication Administration Records (MAR) were reviewed for the months of September and October 2013.</p> <p>Based on record review, 2 of 6 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard:</p> <p>Individual #2 October 2013 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Ativan 1 mg (PRN) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Ativan 1 mg – PRN – 10/9 (given 1 time) • Milk of Magnesia 30 – 60 ml – PRN – 10/1, 5, 7, 8, 9, 12, 13, 14, 17, 18, 19, 21, 23, 24, 25, 27, 28, 29, 30, 31 (given 1 time) <p>Medication Administration Record did not indicated the amount (30 – 60ml) of medication which was assisted with for the following PRN medication:</p> <ul style="list-style-type: none"> • Milk of Magnesia 30 – 60 ml – PRN – 10/1, 5, 7, 8, 9, 12, 13, 14, 17, 18, 19, 21, 23, 24, 25, 27, 28, 29, 30, 31 (given 1 time) <p>Individual #4 October 2013</p>

<p>assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <p>(i) Name of resident;</p> <p>(ii) Date given;</p> <p>(iii) Drug product name;</p>	<p>Medication Administration Records indicate the following medications are both a Routine and a PRN medication. MARs indicates dosages are different, yet both medications are to be given at bedtime. MAR indicates Individual may receive both dosages in a day which would conclude the Individual would receive more than the recommended dose in a 24 hour period on those days. Per PRN Medication Administration Record, Individual is not to exceed 6 Tbsp within a 24 hour period. For January 2013 the Individual exceeded the dosage 18 times in 31 days.</p> <ul style="list-style-type: none"> • Milk of Magnesia 3 Tbsp (1 time daily) Medication was given routinely 1 time daily from January 1 – 31. • Milk of Magnesia 4 Tbsp (PRN) Medication was given 1 time on 1/2, 3, 5, 7, 8, 10, 11, 13, 14, 15, 17, 18, 22, 23, 24, 27, 30, 31. <p>Individual #3 January 2013 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Hydrocortisone Acetate 2.50% (PRN) <p>Individual #4 December 2012 No evidence of documented Signs/Symptoms were found for the following PRN medication:</p> <ul style="list-style-type: none"> • Ativan – PRN – 12/1 (given 1 times) • Ciclopirox 0.77% cream – 12/1 (given 1 time) • Proair HFA 90 mcg – 12/1 (given 1 time) • Polythylene Glycol – 12/1 (given 1 time) 	<p>No evidence of documented Signs/Symptoms were found for the following PRN medication:</p> <ul style="list-style-type: none"> • Ativan 1 mg – PRN – 10/12 & 24 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Ativan 1 mg – PRN – 10/12 & 24 (given 1 time)
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<p>(iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications.</p> <p>Model Custodial Procedure Manual D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> ➤ symptoms that indicate the use of the medication, ➤ exact dosage to be used, and ➤ the exact amount to be used in a 24 hour period. <p>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</p>	<p>January 2013 No evidence of documented Signs/Symptoms were found for the following PRN medication:</p> <ul style="list-style-type: none"> • Polythylene Glycol – 1/15 (given 1 time) <p>Individual #5 December 2012 Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Pepto Bismol (PRN) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Pepto Bismol (PRN) <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Promethazine Syrup (PRN) <p>January 2013 Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Promethazine Syrup (PRN) <p>Individual #6 December 2012 Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Tussin DM Syrup (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Imodium 2 mg (PRN) • Pain Relieve (PRN) 	
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<p>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.</p> <p>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).</p> <p>H. Agency Nurse Monitoring</p> <p>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.</p> <p>Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006</p> <p>C. 3. Prior to delivery of the PRN, direct support</p>	<p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Flunisolide .025 mg (PRN) • Imodium 2 mg (PRN) • Naproxen 220 mg (PRN) • Pain Relieve (PRN) • Sudafed 10 mg (PRN) • Tussin DM Syrup (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Pain Relieve (PRN) <p>Medication Administration Records did not contain the Name of the medication for which the following are prescribed:</p> <ul style="list-style-type: none"> • Pain Relieve (PRN) <p>January 2013</p> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Flunisolide 0.25 mg (PRN) • Imodium 2mg (PRN) • Naproxen (PRN) • Pain Relieve (PRN) • Sudafed PE 10 mg (PRN) <p>Medication Administration Records did not</p>	
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<p>staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).</p> <p>a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.</p> <p>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.).</p>	<p>contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Pain Relieve (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Pain Relieve (PRN) <p>Medication Administration Records did not contain the Name of the medication for which the following are prescribed:</p> <ul style="list-style-type: none"> • Pain Relieve (PRN) <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Pain Relieve (PRN) <p>Individual #7 December 2012</p> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Triazolam .25 mg (PRN) <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Acetaminophen 325 mg (PRN) • Loratadine 10 mg (PRN) <p>January 2013</p> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Acetaminophen 325 mg (PRN) • Loratadine 10 mg (PRN) • Loratadine 10 mg (PRN) 	
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- Olazipine 10 mg (PRN)

Medication Administration Records did not contain the route of administration for the following medications:

- Olazipine 10 mg (PRN)

Medication Administration Records did not contain the circumstance for which the medication is to be used:

- Olazipine 10 mg (PRN)

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:

- Olazipine 10 mg – PRN – 1/29 (given 1 time)

February 2013

Medication Administration Records did not contain the route of administration for the following medications:

- Triazolam .25 mg (PRN)

Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	NA	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDS Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006</p> <p>F. PRN Medication</p> <p>3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical</p>		<p>New Finding:</p> <p>Based on record review, the Agency did not maintain documentation of PRN usage as required by standard for 1 of 6 Individuals.</p> <p>Individual #2 October 2013</p> <p>No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication:</p> <ul style="list-style-type: none"> • Ativan 1 mg – PRN – 10/9 (given 1 time) • Milk of Magnesia 30 – 60 ml – PRN – 10/1, 5, 7, 8, 9, 12, 13, 14, 17, 18, 19, 21, 23, 24, 25, 27, 28, 29, 30, 31 (given 1 time)

<p>attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.</p> <p>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).</p> <p>H. Agency Nurse Monitoring</p> <p>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.</p> <p>Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006</p> <p>C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use</p>		
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<p>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).</p> <p>a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.</p> <p>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.).</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. 		
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Tag # 1A15.2 and 5I09 Healthcare Documentation	Condition of Participation Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</p> <p>(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:</p> <ul style="list-style-type: none"> (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. <p>(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</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency failed to maintain the required documentation in the Individual's Agency Record as required per standard for 7 of 7 individual</p> <p>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Electronic Comprehensive Health Assessment Tool (eCHAT) (#1, 6) • Medication Administration Assessment Tool (#3) • Comprehensive Aspiration Risk Management Plan (#3) • Aspiration Risk Screening Tool (#4, 5) • Health Care Plans <ul style="list-style-type: none"> • <i>Aspiration</i> Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • <i>Body Mass Index</i> <ul style="list-style-type: none"> ◦ Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • <i>Falls</i> 	<p>Repeat Finding:</p> <p>Based on record review, the Agency failed to maintain the required documentation in the Individual's Agency Record as required per standard for 1 of 7 individuals.</p> <p>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Comprehensive Aspiration Risk Management Plan (#3)

<p>the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request.</p> <p>(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.</p> <p>(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 DDS Medication Assessment and Delivery Policy).</p> <p>(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 <i>subjective</i> information including the individual complaints, signs and symptoms noted by staff, family members or other team members; <i>objective</i> information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); <i>assessment</i> of the clinical status, and <i>plan</i> of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.</p> <p>(2) Health related plans</p>	<ul style="list-style-type: none"> ◦ Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #5 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #6 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • <i>Fluid Restriction</i> <ul style="list-style-type: none"> ◦ Individual #2 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • <i>Oral Hygiene</i> <ul style="list-style-type: none"> ◦ Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #7 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • <i>Skin and Wound</i> <ul style="list-style-type: none"> ◦ Individual #5 - According to Electronic 	
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<p>(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.</p> <p>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.</p> <p>(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.</p> <p>(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.</p> <p>(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):</p> <p>(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.</p> <p>(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.</p> <p>(c) Approaches described in the plan shall be</p>	<p>Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.</p> <p>◦ Individual #6 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.</p> <p>• Medical Emergency Response Plans</p> <ul style="list-style-type: none"> • <i>Aspiration</i> ◦ Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • <i>Falls</i> ◦ Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #5 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #6 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • <i>Fluid Restriction</i> ◦ Individual #2 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • <i>Respiratory</i> 	
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<p>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.</p> <p>(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.</p> <p>(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.</p> <p>(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.</p> <p>(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.</p> <p>(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.</p> <p>(4) General Nursing Documentation</p> <p>(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.</p> <p>(b) For individuals with a HAT score of 4, 5 or 6, or</p>	<p>◦ Individual #5 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.</p>	
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<p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS</p> <p>B. IDT Coordination</p> <p>(1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and</p> <p>(2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.</p> <p>Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010</p> <p>F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:</p> <ol style="list-style-type: none"> 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures 		
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<p>that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).</p> <p>4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.</p> <p>5. Emergency contacts with phone numbers.</p> <p>6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.</p>		
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Tag # 1A27 Incident Mgt. Late and Failure to Report	Standard Level Deficiency	Standard Level Deficiency
<p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>A. Duty To Report:</p> <p>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</p> <p>(2) All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:</p> <p>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</p> <p>(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.</p> <p>(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.</p> <p>B. Notification: (1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.</p>	<p>Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 7 individuals.</p> <p>Individual #7</p> <ul style="list-style-type: none"> Incident date 2/7/2012. Allegation was Abuse, Neglect and Exploitation. Incident report was received 2/7/2012. Failure to Report. IMB Late and Failure Report indicated incident of Exploitation was "Confirmed." 	<p>New / Repeat Finding:</p> <p>Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 7 individuals.</p> <p>Individual #6</p> <ul style="list-style-type: none"> Incident date 7/31/2013. Allegation was Exploitation. Incident report was received 8/6/2013. Late Reporting. IMB Late and Failure Report indicated incident of Exploitation was "Unconfirmed" and Neglect was "Confirmed."]

Standard of Care	Routine Survey Deficiencies February 18 - 21, 2013	Verification Survey New and Repeat Deficiencies November 18 - 19, 2013
Service Domain: Service Plans: ISP Implementation – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.		
Tag # 1A08 Agency Case File	Standard Level Deficiency	Completed
Tag # 5I11 Reporting Requirements Community Inclusion Reports	Standard Level Deficiency	Completed
Tag # 6L14 Residential Case File	Standard Level Deficiency	Completed
Tag # 6L17 Reporting Requirements (Community Living Reports)	Standard Level Deficiency	Completed
Service Domain: Qualified Providers – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.		
Tag # 1A11.1 Transportation Training	Standard Level Deficiency	Completed
Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency	Completed
Tag # 1A22 Agency Personnel Competency	Standard Level Deficiency	Completed
Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency	Completed
Tag # 1A36 Service Coordination Requirements	Standard Level Deficiency	Completed
Service Domain: Health and Welfare – The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.		
Tag # 1A03 CQI System	Standard Level Deficiency	Completed
Tag # 1A05 General Provider Requirements	Standard Level Deficiency	Completed
Tag # 1A28.2 Incident Mgt. System -	Standard Level Deficiency	Completed

Parent/Guardian Training		
Tag # 6L13 Community Living Healthcare Reqts.	Standard Level Deficiency	Completed
<i>Service Domain: Medicaid Billing/Reimbursement – State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</i>		
TAG #1A12 All Services Reimbursement	No Deficiencies Found	

Date: December 17, 2013

To: Christine Chapman, Executive Director
Provider: Safe Harbor, Inc.
Address: 506 S. Main Ste 908
State/Zip: Las Cruces, New Mexico 88001
E-mail Address: garychpm@aol.com

CC: Bonnie Chapman, Assistant Director
Address: 506 S. Main Ste 908
State/Zip: Las Cruces, New Mexico 88001
E-mail Address: bonbonexpress@yahoo.com

Region: Southwest
Routine Survey: February 18 - 21, 2013
Verification Survey: November 18 - 19, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living) and Community Inclusion Supports (Adult Habilitation)
Survey Type: Verification

Dear Ms. Chapman;

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

The Plan of Correction process is now complete.

To maintain ongoing compliance with standards and regulations, continue to use the Quality Assurance (self-auditing) processes you described in your Plan of Correction.

Consistent use these Quality Assurance processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies cited in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, for striving to come into compliance with standards and regulations, and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,



Crystal Lopez-Beck
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.14.2.DDW.79902782.3.001.VER.09.351