Date:	November 19, 2010
To:	Kathy Chavez, President
Provider:	Silver Lining Services, LLC.
Address:	1447 East Roosevelt
State/Zip:	Grants, New Mexico 87020
E-Mail Address:	kchavez@7cities.net
CC:	Kevin Chavez, Executive Director
Address:	1447 East Roosevelt
State/Zip	Grants, New Mexico 87020
Region:	Northwest
Original Survey Date:	March 15 - 18, 2010
Verification Survey:	October 25 - 26, 2010
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Survey Type:	Verification
Team Leader:	Maurice Gonzales, BS Health Ed., Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Chavez

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 you Plan of Correction submitted to DHI/DDSD regarding the Routine Survey on ***March 15 – 18, 2010.***

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

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

Sincerely,

Maurice Gonzales, BS

Maurice Gonzales, BS Health Education
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	October 25, 2010
Present:	**Silver Lining Services, LLC.** Jacqueline Jaramillo, Director of Operations Bernadine Leekela, Program Manager **DOH/DHI/QMB** Maurice Gonzales, BS Health Ed, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor
Exit Conference Date:	October 26, 2010
Present:	**Silver Lining Services, LLC.** Jacqueline Jaramillo, Director of Operations Bernadine Leekela, Program Manager **DOH/DHI/QMB** Maurice Gonzales, BS Health Ed, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 5 1 - Jackson Class Members 4 - Non-Jackson Class Members 1 - Supported Living 4 - Family Living 5 - Adult Habilitation 3 - Community Access 2 - Supported Employment
Records Reviewed (Persons Served)	Number: 5
Administrative Files Reviewed	• Billing Records • Medical Records • Incident Management Records • Personnel Files • Training Records • Agency Policy and Procedure • Caregiver Criminal History Screening Records • Employee Abuse Registry • Human Rights Notes and/or Meeting Minutes • Nursing personnel files • Evacuation Drills • Quality Improvement/Quality Assurance Plan

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

Attachment B

QMB Scope and Severity Matrix

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

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

Scope and Severity Definitions:

- Isolated:

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

- Pattern:

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

- Widespread:

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

QMB Determinations of Compliance

- "Substantial Compliance with Conditions of Participation"

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

- "Non-Compliance with Conditions of Participation"

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

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

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

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

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

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

Attachment C

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

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

Instructions:

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

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

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

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

The following limitations apply to the IRF process:

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

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is 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: **Silver Lining Services, LLC. - Northwest Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Initial Survey
Date of Original Survey: March 15 - 18, 2010
Date of Verification Survey: October 25-26, 2010

Standard of Care	March 15 – 18, 2010 Deficiencies	October 25 - 26, 2010 Verification Survey - New and Repeat Deficiencies
Tag # 1A03 CQI System	**Scope and Severity Rating: C**	**Scope and Severity Rating: NA**
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS** **I. Continuous Quality Management System:** Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents	Based on record review and interview, the Agency failed to establish and implement a quality improvement system for reviewing alleged complaints and incidents. Review of the Agency's Quality Improvement regarding incident management did not contain the following: 4) community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues. When #74 was asked if the Agency had an Incident Management Quality Improvement System, which included, a process for reviewing alleged, complaints & incident; documentation of internal investigations of alleged violations; reasonable steps taken to prevent further incident and documentation of corrective active, the following was reported when asked about tracking and trending: #74, stated, "Quarterly meetings are kept on file and reviewed by the committee; training and tracking began last month"	Complete

leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction. **7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:** **E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system: **(1)** community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements; **(2)** community based service providers providing developmental disabilities services must have a designated incident management coordinator in place; **(4)** community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.		

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

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

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: E	Scope and Severity Rating: E
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. E. **Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the	Medication Administration Records (MAR) were reviewed for the months of December 2009, January, February & March 2010 Based on record review, 4 of 5 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #1 December 2009 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications: • Paxil 30mg (1 time daily) • Aspirin 81mg (1 time daily) January 2010 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications: • Paxil 30mg (1 time daily) • Aspirin 81mg (1 time daily) Individual #2 December 2009 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications: • Levothyroxin 100mcg (1 time daily) • Gluophage 500mg (1 time daily)	**New & Repeat Findings:** Medication Administration Records (MAR) were reviewed for the months of August & September 2010 Based on record review, 2 of 5 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #3 August 2010 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Claritin 10mg (1 time daily) • Flonase 50mcg (2 times daily) • Augmentin 875mg (2 times daily) September 2010 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Colace 100mg (1 time daily) • Claritin 10mg (1 time daily) • Flonase 50mcg (2 times daily) Individual #5 August 2010 As indicated by the Medication Administration Records the individual is to take Primidone 250mg (1/2 tab every AM). According to the Physician's Orders, Primidone 250mg is to be taken 3 times daily. Medication Administration Record & Physician's Orders do not match.

use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications.	January 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Amoxicillin 250mg (4 times daily) March 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Gluophage 500mg (1 time daily) – Blank 3/12 During on site visit on 3/16/2010 at 5:00 pm, Surveyors observed the Medication Administration Record were posted dated and initialed for 3/20, 21, 27 & 28 for following medication: • Gluophage 500mg (1 time daily) Individual #3 December 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Clotrimazole 1% cream (2 times daily) – Blank 12/25, 26 & 27 (8AM) & 12/25, 26, 29 & 31 (8PM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Citalopram 20mg (1 time daily) January 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries • Clotrimazole 1% cream (2 times daily) – Blank 1/3, 7, 8 & 24 (8AM) • Citalopram 20mg (1 time daily) – Blank 1/7 (8AM) Medication Administration Records did not contain the diagnosis for which the medication is	As indicated by the Medication Administration Records the individual is to take Klor-Con M10 (1 tab every AM). According to the Physician's Orders, individual is to take Klor-Con 75mg. Medication Administration Record & Physician's Orders do not match. As indicated by the Medication Administration Records the individual is to take Tums 500mg (1 tab 3 times daily). According to the Physician's Orders, Calcium 1200mg is to be taken 1 times daily. Medication Administration Record & Physician's Orders do not match. September 2010 As indicated by the Medication Administration Records the individual is to take Primidone 250mg (1/2 tab every AM). According to the Physician's Orders, Primidone 250mg is to be taken 3 times daily. Medication Administration Record & Physician's Orders do not match. As indicated by the Medication Administration Records the individual is to take Klor-Con M10 (1 tab every AM). According to the Physician's Orders, individual is to take Klor-Con 75mg. Medication Administration Record & Physician's Orders do not match. As indicated by the Medication Administration Records the individual is to take Tums 500mg (1 tab 3 times daily). According to the Physician's Orders, Calcium 1200mg is to be taken 1 times daily. Medication Administration Record & Physician's Orders do not match.

Model Custodial Procedure Manual ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period.	prescribed: • Citalopram 20mg (1 time daily) Individual #5 December 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Potassium Chloride (1 time daily) Medication Administration Records did not contain the strength for the following medications: • Valproic Acid (2 times daily) • Valproic Acid (1 time daily) • Potassium Chloride (1 time daily) January 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed • Potassium Chloride (1 time daily) Medication Administration Records did not contain the strength for the following medications: • Valproic Acid (2 times daily) • Valproic Acid (1 time daily) • Potassium Chloride (1 time daily) February 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Levothyroxin 25mcg (1 time daily) – Blank 2/28 (8AM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed • Azithromtcin 200mg (1 time daily)	

	• Zyrtec 10 mg (1 time daily) • Potassium Chloride (1 time daily)	

Tag # 1A09 Medication Delivery - PRN Medication	Scope and Severity Rating: E	Scope and Severity Rating: E
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 2 of 5 Individuals. Individual #2 December 2009 Medication Administration Records did not contain the dosage for the following medications: • Midol (PRN) Medication Administration Records did not contain the circumstance for which the medication is to be used: • Midol (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Midol – PRN – 12/27, 28, 29, 30 & 31 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Midol – PRN – 12/27, 28, 29, 30 & 31 (given 1 time daily) Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications: • Midol (PRN) January 2010 Medication Administration Records did not contain the dosage for the following medications: • Midol (PRN)	**New & Repeat Finding:** Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 1 of 5 Individuals. Individual #3 August 2010 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Codeine 5ml (1 teaspoon every 8 hours not to exceed 3 doses in 24 hours) (PRN)

use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering	Medication Administration Records did not contain the circumstance for which the medication is to be used: • Midol (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Midol – PRN – 1/18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28 & 29 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Midol – PRN – 1/18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28 & 29 (given 1 time daily) February 2010 Medication Administration Records did not contain the dosage for the following medications: • Midol (PRN) Medication Administration Records did not contain the circumstance for which the medication is to be used: • Midol (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Midol – PRN – 2/1, 2, 3, 4, 5, 6, 7, 20, 21, 22, 23, 24, 25, 26 & 27 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Midol – PRN – 2/1, 2, 3, 4, 5, 6, 7, 20, 21, 22, 23, 24, 25, 26 & 27 (given 1 time daily) Individual #3 December 2009 No Effectiveness was noted on the Medication	

medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period. **Department of Health** **Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006** **F. PRN Medication** 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual. 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	Administration Record for the following PRN medication: • Tylenol 325mg or 500mg – (PRN) - 12/27 (given 1 time daily) Individual #5 February 2010 Medication Administration Records did not contain the circumstance for which the medication is to be used: • Tylenol 325mg or 500mg - (PRN)	

and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).		

a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).		

Tag # 1A11 (CoP) Transportation Training	Scope and Severity Rating: E	Scope and Severity Rating: NA
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **G. Transportation:** Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety". The policy and procedures must address at least the following topics: (1) Drivers' requirements, (2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions, (3) Vehicle maintenance and safety inspections, (4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures, (5) Emergency Plans, including vehicle evacuation techniques, (6) Documentation, and (7) Accident Procedures**.** **Department of Health (DOH)** **Developmental Disabilities Supports Division (DDSD) Policy** Training Requirements for Direct Service Agency Staff	Based on record review the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 9 of 31 Direct Service Personnel. No documented evidence was found of the following required training: • Transportation (DSP #43, 51, 53, 57, 58, 59, 61, 64 & 67)	Complete

Policy **Eff Date:** March 1, 2007 **II. POLICY STATEMENTS:** I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)		

Tag # 1A12 Reimbursement/Billable Units	Scope and Severity Rating: B	Scope and Severity Rating: NA
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed, which contained the required information for 3 of 5 individuals. Individual #2 December 2009 • The Agency billed 28 units of Family Living from 12/1/2009 through 12/31/2009. Documentation on 12/1, 2, 3, 4, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 did not contain start and end time to justify billing. January 2010 • The Agency billed 1 unit of Family Living on 1/1/2010. Documentation did not contain start and end time to justify billing. February 2010 • The Agency billed 1 units of Family Living on 2/1/2010. Documentation did not contain start and end time to justify billing. Individual #4 February 2010 • The Agency billed 14 units of Family Living from 2/1/2010 through 2/14/2010. Documentation on 2/10, 11 & 12 did not contain start and end time to justify billing. Individual #5 January 2010 • The Agency billed 28 units of Family Living from 1/1/2010 through 1/31/2010. Documentation on 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 & 28 did not contain start and end time to justify billing. February 2010 • The Agency billed 14 units of Family Living from 2/1/2010 – 2/14/2010. Documentation on 2/1, 2,	Complete

	3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 &14 did not contain start and end time to justify billing.	

Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: E	Scope and Severity Rating: D
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **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. **Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities** (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request. (c) For newly allocated individuals, the HAT and the	Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 2 of 5 individual The following were not found, incomplete and/or not current: • **Special Health Care Needs:** • Initial Nutritional Evaluation ◦ Individual #1 - According to SAFE evaluation the individual is required to have an evaluation. Decision Justification Document states, "Team to implement SAFE recommendations." No evidence of an evaluation was found. • Meal Time Plan ◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. No plan was found. • Nutritional Plan ◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. No plan was found.	**Repeat Finding:** Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 1 of 5 individual The following were not found, incomplete and/or not current: • **Special Health Care Needs:** • Meal Time Plan ◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. No plan was found. • Nutritional Plan ◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. No plan was found.

MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first. (d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy). (e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as *subjective* information including the individual complaints, signs and symptoms noted by staff, family members or other team members; *objective* information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants. **(2) Health related plans** (a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional. (b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan. (c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered		

to agency staff and other team members, clearly indicating competency determination for each trainee. (d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings. (3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended): (a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition. (b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal. (c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan. (d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions. (e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency		

determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings. (f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization. (g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author. (h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed. **(4) General Nursing Documentation** (a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person. (b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.		

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E	Scope and Severity Rating: NA
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 22 of 31 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #61, 62, 66, 67, 68 ,69 & 70) • Basic Health/Orientation (DSP #54, 62, 66, 67, 68, 69 & 70) • Person-Centered Planning (1-Day) (DSP #51, 54, 58, 60, 67, 68 & 70) • First Aid (DSP #46, 49, 52, 53, 54, 60, 64, 65, 66, 67, 68 & 69) • CPR (DSP #46, 49, 52, 53, 54, 64, 65, 66, 67, 68, 69 & 70) • Assisting With Medication Delivery (DSP #40, 43, 46, 48, 52, 53, 56, 57, 58, 66, 67, 68, 69 &70)	Complete

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

Tag # 1A22 Staff Competence	Scope and Severity Rating: E	Scope and Severity Rating: NA
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **F. Qualifications for Direct Service Personnel:** The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency: (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and	Based on interview, the Agency failed to ensure that training competencies were met for 3 of 10 Direct Service Personnel. **When DSP were asked if they received training on the Individual's Speech Therapy Plan and what the plan covered, the following was reported:** • DSP #49 stated, "No, I haven't been trained." According to the Individual Specific Training Section of the ISP. The Individual requires a Speech Therapy Plan. (Individual #3) **When DSP were asked if they received training on the Individual's Seizure Crisis Plan and what the plan covered, the following was reported:** • DSP # 62 stated, "Read doctor's notes." "No plan on file." The DSP did not refer to seizure plan. As indicated by the Agency Case File, the Individual has a Crisis Plan for Seizures. (Individual #5) **When DSP were asked if they had received training regarding the individual's Seizure Disorder, the following was reported:** • DSP #64 stated, "Never had training on #5's seizure disorder ". According to the ISP, the individual has a diagnosis of Seizures. (Individual #5) **When DSP were asked if there is a person specific seizure plan/crisis plan. Regarding the individual's Seizure Disorder, the following was reported:** • DSP # 64 stated, " No, not that I know of." According to the Agency Case File, the Individual has Crisis Plan for Seizures. (Individual #5) **When DSP were asked if they received training on the Individuals' Meal Time Plans and what the plan**	Complete

(5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support. (6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows: (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff	**covered, the following was reported:** • DSP #49 stated, "She has no plan." As indicated by the Individual Specific Training section of the ISP the individual has a Meal Time Plan). (Individual #3)	

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D	Scope and Severity Rating: NA
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:** **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11** **DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.	Based on record review, the Agency failed to maintain documentation indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 2 of 31 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** • # 40 – Date of hire 5/1/2009 • # 54 – Date of hire 9/1/2009	Complete

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E	Scope and Severity Rating: D
NMAC 7.1.12.8 **REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED**: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing	Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 23 of 32 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry being completed:** • #40 – Date of hire 5/1/2009 • #59 – Date of hire 11/14/2009 **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** • #41 – Date of hire 12/2/2009. Completed 12/3/2009. • #42 – Date of hire 6/1/2009. Completed 11/2/2009. • #43 – Date of hire 6/3/2009. Completed 11/2/2009. • #45 – Date of hire 1/4/2010. Completed 1/14/2010. • #47 – Date of hire 5/1/2009. Completed 11/2/2009. • #49 – Date of hire 5/6/2009. Completed 11/2/2009. • #50 – Date of hire 5/27/2009. Completed 11/2/2009. • #51 – Date of hire 5/7/2009. Completed 12/7/2009.	**New & Repeat Finding:** Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 1 of 28 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** #76 – Date of hire 5/20/2010. Completed 5/25/2010

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.	• #54 – Date of hire 9/1/2009. Completed 12/2/2009. • #55 – Date of hire 1/1/2010. Completed 1/19/2010. • #56 – Date of hire 12/15/2009. Completed 1/19/2010. • #57 – Date of hire 8/17/2009. Completed 9/8/2009. • #58 – Date of hire 8/17/2009. Completed 11/2/2009. • #60 – Date of hire 11/20/2009. Completed 1/26/2010. • #61 – Date of hire 1/1/2010. Completed 2/2/2010. • #62 – Date of hire 5/27/2009. Completed 8/11/2009. • #63 – Date of hire 5/27/2009. Completed 11/2/2009. • #65 – Date of hire 10/28/2009. Completed 11/6/2009. • #66 – Date of hire 10/27/2009. Completed 11/2/2009. • #68 – Date of hire 10/30/2009. Completed 11/2/2009. • #73 – Date of hire 10/5/2009. Completed 3/18/2010.	

Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: E	Scope and Severity Rating: NA
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007** **II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.	Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 10 of 32 Agency Personnel. • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#41, 42, 53, 54, 58, 60, 62, 64, 67 & 70)	Complete

Tag # 1A28 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: D	Scope and Severity Rating: NA
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **E. Consumer and Guardian Orientation Packet:** Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 1 of 5 individuals. • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#3)	Complete

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: E	Scope and Severity Rating: NA
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (2) **Individual-specific training** for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** **A.** Individuals shall receive services from competent and qualified staff. **B.** Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.	Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 18 of 32 Agency Personnel. Review of personnel records found no evidence of the following: • Individual Specific Training (#40, 47, 52, 53, 54, 55, 56, 57, 58, 60, 61, 62, 64, 65, 66, 67, 68 & 69)	Complete

Tag # 5I22 SE Agency Case File	Scope and Severity Rating: B	Scope and Severity Rating: A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS** **D. Provider Agency Requirements** (1) Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDSD. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits. (2) The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items: (a) Quarterly progress reports; (b) Vocational assessments (A vocational assessment or profile is an objective analysis of a person's interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDSD; (c) Career development plan as incorporated in the ISP; a career development plan consists of the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks including the individual, as well and a review and reporting mechanism for mutual accountability; and	Based on record review, the Agency failed to maintain a confidential case file for each individual for 1 of 2 individuals receiving Supported Employment Services. The following were not found, incomplete and/or not current: • Vocational Assessment (#1)	**New Finding:** Based on record review, the Agency failed to maintain a confidential case file for each individual for 1 of 2 individuals receiving Supported Employment Services. The following were not found, incomplete and/or not current: • Required Certificates & Documentation ◦ Documentation of decisions concerning DVR that services provided under the Waiver are not otherwise available.(#1)

(d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973. New Mexico Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy **Policy Title: Vocational Assessment Profile Policy Eff July 16, 2008** **I. PURPOSE** The intent of the policy is to ensure that individuals are identified who could benefit from Vocational Assessment Profiles (VAPs) and are supported to access this support. **II. POLICY STATEMENT** Individuals served under the Developmental Disabilities Medicaid Waiver (DDW) who express an interest in obtaining employment or exploring employment opportunities, or individuals who desire a VAP and those whose teams identify that they could benefit from a VAP, will have access to a VAP in accordance to the DDW Service Standards and related procedures.		

Tag # 5I36 CA Reimbursement	Scope and Severity Rating: A	Scope and Severity Rating: NA
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS** **G. Reimbursement** (1) Billable Unit**:** A billable unit is defined as one-quarter hour of service. (2) Billable Activities**:** The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan; (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and (c) Non face-to-face hours do not exceed 10% of the monthly billable hours. (3) Non-Billable Activities**:** Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include: (a) Time and expense for training service personnel; (b) Supervision of agency staff; (c) Service documentation and billing activities; or (d) Time the individual spends in segregated facility-based settings activities.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 1 of 3 individuals. Individual #3 February 2010 • The Agency billed 78 units of Community Access from 2/6/2010 through 2/7/2010. No documentation found to justify billing.	Complete

Tag # 5I44 AH Reimbursement	Scope and Severity Rating: C	Scope and Severity Rating: B
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XVI. REIMBURSEMENT** **A. Billable Unit**. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care. **B. Billable Activities** (1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours. (2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 5 of 5 individuals. Individual #1 December 2009 • The Agency billed 590 units of Adult Habilitation from 12/1/2009 through 12/31/2009. Documentation received accounted for 405 units. Individual #2 December 2009 • The Agency billed 171 units of Adult Habilitation from 12/1/2009 through 12/31/2009. Documentation received accounted for 128 units. January 2010 • The Agency billed 226 units of Adult Habilitation from 1/1/2010 through 1/31/2010. Documentation received accounted for 105 units. Individual #3 January 2010 • The Agency billed 437 units of Adult Habilitation from 1/1/2010 through 1/31/2010. Documentation received accounted for 212 units. Individual #4 December 2009 • The Agency billed 776 units of Adult Habilitation from 12/1/2009 through 12/31/2009. Documentation received accounted for 576 units. February 2010 • The Agency billed 320 units of Adult Habilitation from 2/1/2010 through 2/31/2010. Documentation received accounted for 304 units. Individual #5 January 2010	**New & Repeat Findings:** Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 3 of 5 individuals. Individual #1 September 2010 • The Agency billed 464 units of Adult Habilitation from 9/1/2010 through 9/30/2010. Documentation received accounted for 382 units. Individual #3 August 2010 • The Agency billed 421 units of Adult Habilitation from 8/1/2010 through 8/31/2010. Documentation received accounted for 393 units. Individual #5 September 2010 • The Agency billed 586 units of Adult Habilitation from 9/1/2010 through 9/30/2010. Documentation received accounted for 548 units.

	• The Agency billed 600 units of Adult Habilitation from 1/1/2010 through 1/31/2010. Documentation received accounted for 590 units. February 2010 • The Agency billed 438 units of Adult Habilitation from 2/1/2010 through 2/31/2010. Documentation received accounted for 432 units.	

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E	Scope and Severity Rating: NA
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by	Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 3 of 5 individuals receiving Community Living Services. • **Dental Exam** ◦ Individual #3 - As indicated by the documentation reviewed, the individual was last seen on 7/16/2008. The Individual was to return in 8 weeks. No evidence of exam was found. • **Vision Exam** ◦ Individual #2 - As indicated by the DDSD file matrix Visions Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #3 - As indicated by Doctor's annual vision exam on11/28/2006. Follow-up was to be completed annually. No evidence of exam was found. ▪ **Cholesterol & Blood Glucose** ◦ Individual #1 - As indicated by the documentation reviewed, lab work was ordered on 2/24/2010. No evidence found to verify it was completed.	Complete

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

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

(9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings…		

Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: F	Scope and Severity Rating: NA
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services** (1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has: (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence; (b) General-purpose first aid kit; (c) When applicable due to an individual's health status, a blood borne pathogens kit; (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats; (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone; (f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift; (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.	Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 5 of 5 Supported Living & Family Living residences. The following items were not found, not functioning or incomplete: **Supported Living Requirements:** • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#3) **Family Living Requirements:** • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#1) • Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift (#1, 2 & 4) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#1, 2 & 5) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 2 & 4)	Complete

Tag # 6L27 FL Reimbursement	Scope and Severity Rating: B	Scope and Severity Rating: NA
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES** B. Reimbursement for Family Living Services (1) Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year. (2) Billable Activities shall include: (a) Direct support provided to an individual in the residence any portion of the day; (b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and (c) Any other activities provided in accordance with the Scope of Services. (3) Non-Billable Activities shall include: (a) The Family Living Services Provider Agency may not bill the for room and board; (b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and (c) Family Living services may not be billed for the same time period as Respite. (d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one midnight to the following midnight.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 2 of 4 individuals. Individual #1 December 2009 • The Agency billed 28 units of Family Living from 12/1/2009 through 12/31/2010. Documentation received accounted for 16 units. Individual #2 December 2009 • The Agency billed 5 units of Family Living from 12/5/2009 through 12/9/2010. No documentation found to justify billing.	Complete

Date: December 9, 2010

To: Kevin Chavez, Executive Director
Provider: Silver Lining Services, LLC.
Address: 1447 East Roosevelt
State/Zip: Grants, New Mexico 87020

E-Mail Address: jacqjara@slsnm.net

Region: Northwest
Original Survey Date: March 15 - 18, 2010
Verification Survey: October 25 - 26, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)

RE: Request for an Informal Reconsideration of Findings

Dear Mr. Chavez,

Your request for a Reconsideration of Findings was received on December 6, 2010. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A09.1
Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, deficiencies noted in tag 1A09.1 regarding Individual #3's Physician's orders were requested during the home visit from Patricia Pasquale (#76) on 10/25/10 at 2:45 PM. Ms. Pasquale signed verifying the request was made and she was unable to locate the orders. In regards to Individual #5, the use of "Primidone 250 MG 1 tablet Three times a day; Potassium 75 MG as directed; and Calcium 1200 mg one tab daily" *[sic]* was taken from an electronically signed physician's progress note dated 9/10/10 by Arnold W. Valdivia, MD. The remaining citations noted in this tag were not disputed. The scope and severity rating for this tag will remain "E."

Regarding Tag # 1A09.2
Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, deficiencies noted in tag 1A09.1 regarding Individual #3's Physician's orders were requested during the home visit from Patricia Pasquale (#76) on 10/25/10 at 2:45 PM. Ms. Pasquale signed verifying the request was made and she was unable to locate the orders.

Regarding Tag # 1A15
Determination: The IRF committee is modifying the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, deficiencies noted in tag 1A15 regarding Individual #3's missing Nutritional Plan will be removed. The remaining citations noted in this tag were not disputed. The scope and severity rating for this tag will remain "D."

Regarding Tag # 1A26
Determination: The IRF committee is removing the original finding in the report.

Regarding Tag # 5I44
Determination: The IRF committee is removing the original finding in the report.

Due to these findings the recently requested Directed Plan of Correction (DPOC) will be modified in the following ways: The DPOC regarding tag #5I44 will be rescinded and you will not be required to respond this that particular DPOC.

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

Thank you.

Respectfully,

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

CC:
File
DHI
DDSD