Date:	February 12, 2010
To:	Michael Binkley, President
Provider:	Su Vida Services, Inc.
Address:	8501 Candelaria NE Building A
State/Zip:	Albuquerque, New Mexico 87112
E-mail Address:	mikebinkley@suvidaservices.com
CC:	Patsy Rios, Board Chair
Address:	1001 Dakota SE
State/Zip	Albuquerque, New Mexico
Boardchair E-Mail Address:	patsyrios@suvidaservices.com
Region:	Metro, Northeast & Northwest
Survey Date:	January 4 – 11, 2010
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Community Living (Supported Living, Independent Living & Family Living) & Community Inclusion (Adult Habilitation & Community Access)
Survey Type:	Routine
Team Leader:	Crystal Lopez-Beck, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Florie Alire, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Maurice Gonzales, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Barbara Czinger, MSW, LISW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Cynthia Nielsen, MSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Stephanie Martinez de Berenger, MPA, GCDF, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Lori Dury, Metro Social & Community Coordinator, Developmental Disabilities Support Division & Dennis O'Keefe, NW Social & Community Coordinator, Developmental Disabilities Support Division

Dear Mr. Binkley,

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Crystal Lopez-Beck, BA

Crystal Lopez-Beck, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	**January 4, 2010**
Present:	**Su Vida Services, Inc.** Mike Binkley, President Vicki Miracle, Chief Financial Officer Patsy Rios, Vice President of Operations **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Team Lead/Healthcare Surveyor Nadine Romero, LBSW, Healthcare Surveyor Florie Alire, RN, Healthcare Surveyor Maurice Gonzales, BS, Healthcare Surveyor Barbara Czinger, MSW, LISW, Healthcare Surveyor Cynthia Nielsen, MSN, Healthcare Surveyor **DDSD – Metro & NW Regional Office** Lori Dury, Community Inclusion Coordinator (Metro) Dennis O'Keefe, Social & Community Coordinator (NW)
Exit Conference Date:	January 7, 2010
Present:	**Su Vida Services, Inc.** Mike Binkley, President Vicki Miracle, Chief Financial Officer Patsy Rios, Vice President of Operations Julianna Baca, Family Living Support Coordinator Andrea Anaya, Community Living Service Coordinator Tippi Watson, Director of Quality Assurance & Training Rhonda O'Brien, Family Living Support Coordinator Marian Jones, Family Living Coordinator & Trainer Christi Greene, Day Supports Manager Paola Lima, Day Supports Coordinator **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor Nadine Romero, LBSW, Healthcare Surveyor **DDSD - Metro Regional Office** Lori Dury, Community Inclusion Coordinator
Homes Visited	Number: 19
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 24 3 - Jackson Class Members 21 - Non-Jackson Class Members 2 - Supported Living 17 - Family Living 2 - Independent Living 12 - Adult Habilitation 14 - Community Access
Persons Served Interviewed	Number: 14

Persons Served Observed	Number: 10 (6 Individuals were unavailable during the on-site week of January 4, 2010; 4 Individuals chose not to answer interview questions asked by surveyors)
Records Reviewed (Persons Served)	Number: 24
Administrative Files Reviewed	• Billing Records • Medical Records • Incident Management Records • Personnel Files • Training Records • Agency Policy and Procedure • Caregiver Criminal History Screening Records • Employee Abuse Registry • Human Rights Notes and/or Meeting Minutes • Nursing personnel files • Evacuation Drills • Quality Improvement/Quality Assurance Plan

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

Attachment A

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

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

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

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

Attachment B

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

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

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

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

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

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

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

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

The QMB Approval Rating

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

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

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

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

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

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

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

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

Attachment C

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

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

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

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

The following limitations apply to the IRF process:

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

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

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

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

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

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

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

Agency: **Su Vida Services, Inc. - Metro, Northwest & Northeast Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living, Family Living & Independent Living) & Community Inclusion (Adult Habilitation & Community Access)
Monitoring Type: Routine Survey
Date of Survey: **January 4 – 11, 2010**

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A08 Agency Case File	**Scope and Severity Rating: A**		
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	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 4 of 24 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • Speech Therapy Plan (#4, 5, 11 & 16)		

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

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and	Medication Administration Records (MAR) were reviewed for the months of September, October & November 2009. Based on record review, 10 of 19 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #1 September 2009 Medication Administration Records did not contain the frequency of medication to be given: • Felbatol 600mg • Carbatrol 200mg • Carbatrol 300mg • Acetazolamide 250mg • Vitamin D 1000mg Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Felbatol 600mg • Carbatrol 200mg • Carbatrol 300mg • Acetazolamide 250mg • Vitamin D 1000mg Medication Administration Records did not contain the route of administration for the following medications: • Felbatol 600mg		

(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff	• Carbatrol 200mg • Carbatrol 300mg • Acetazolamide 250mg • Vitamin D 1000mg Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Felbatol 600mg – Blank 09/01, 03, 04, 08, 10, 11 14, 17, 21, 22, 24, 25, 28 & 29 (Noon) • Acetazolamide 250mg – Blank 09/24 (8AM) October 2009 Medication Administration Records did not contain the frequency of medication to be given: • Felbatol 600mg • Carbatrol 200mg • Carbatrol 300mg • Acetazolamide 250mg • Vitamin D 1000mg Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Felbatol 600mg • Carbatrol 200mg • Carbatrol 300mg • Acetazolamide 250mg		

administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period.	• Vitamin D 1000mg Medication Administration Records did not contain the route of administration for the following medications: • Felbatol 600mg • Carbatrol 200mg • Carbatrol 300mg • Acetazolamide 250mg • Vitamin D 1000mg Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Felbatol 600mg – Blank 10/01, 02, 05, 06, 08, 09, 11, 12, 15, 16, 19, 20, 22, 23, 26, 27, 29 & 30 ("Noon") November 2009 Medication Administration Records did not contain the frequency of medication to be given: • Felbatol 600mg • Carbatrol 200mg • Carbatrol 300mg • Acetazolamide 250mg • Vitamin D 1000mg • Comtrex Cold Pill Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Felbatol 600mg		

	• Carbatrol 200mg • Carbatrol 300mg • Acetazolamide 250mg • Vitamin D 1000mg • Comtrex Cold Pill Medication Administration Records did not contain the route of administration for the following medications: • Felbatol 600mg • Carbatrol 200mg • Carbatrol 300mg • Acetazolamide 250mg • Vitamin D 1000mg • Comtrex Cold Pill Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Felbatol 600mg – Blank 11/02, 03, 05, 06, 12, 13, 16, 17, 19, 23, 24 & 30 (Noon) Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard: • Comtrex Cold Pill Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Comtrex Cold Pill		

	Individual #2 September 2009 As indicated by the Medication Administration Records the individual is to take Levothyroxine 100mg (1 time daily). According to the Physician's Orders, Levothyroxine 100mcg is to be taken 1 time daily. Medication Administration Record & Physician's Orders do not match. October 2009 As indicated by the Medication Administration Records the individual is to take Levothyroxine 100mg (1 time daily). According to the Physician's Orders, Levothyroxine 100mcg is to be taken 1 time daily. Medication Administration Record & Physician's Orders do not match. November 2009 As indicated by the Medication Administration Records the individual is to take Levothyroxine 100mg (1 time daily). According to the Physician's Orders, Levothyroxine 100mcg is to be taken 1 time daily. Medication Administration Record & Physician's Orders do not match. Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Simvastatin 10mg (1 time daily) Medication Administration Records did not contain the route of administration for the following medications: • Simvastatin 10mg (1 time daily) Individual #4 September 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Depakote 125mg (2 times daily)		

	October 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Depakote 125mg (2 times daily) Individual #6 September 2009 Medication Administration Records did not indicate the dosage administered: • Fluoxetine 120ml, 20mg/5ml up to 3 teaspoons daily October 2009 Medication Administration Records did not indicate the dosage administered: • Fluoxetine 120ml, 20mg/5ml up to 3 teaspoons daily November 2009 Medication Administration Records did not indicate the dosage administered: • Fluoxetine 120ml, 20mg/5ml up to 3 teaspoons daily Individual #9 September 2009 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Inderal LA 80mg (1 time daily) • Propranolol 20mg (1 time daily) • Wal-tin Loratadine 10mg (1 time daily) • Propranolol 80mg (1 time daily) • Tri-Sprintec (1 time daily) Medication Administration Records did not contain the diagnosis for which the medication is		

	prescribed: • Inderal LA 80mg (1 time daily) • Propranolol 20mg (1 time daily) • Wal-tin Loratadine 10mg (1 time daily) • Propranolol 80mg (1 time daily) • Tri-Sprintec (1 time daily) Medication Administration Records did not contain the dosage for the following medications: • Tri-Sprintec (1 time daily) Medication Administration Records did not contain the route of administration for the following medications: • Tri-Sprintec (1 time daily) October 2009 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Inderal LA 80mg (1 time daily) • Propranolol 20mg (1 time daily) • Wal-tin Loratadine 10mg (1 time daily) • Propranolol 80mg (1 time daily) • Tri-Sprintec (1 time daily) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Inderal LA 80mg (1 time daily) • Propranolol 20mg (1 time daily)		

	• Wal-tin Loratadine 10mg (1 time daily) • Propranolol 80mg (1 time daily) • Tri-Sprintec (1 time daily) Medication Administration Records did not contain the dosage for the following medications: • Tri-Sprintec (1 time daily) Medication Administration Records did not contain the route of administration for the following medications: • Tri-Sprintec (1 time daily) November 2009 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Inderal LA 80mg (1 time daily) • Propranolol 20mg (1 time daily) • Wal-tin Loratadine 10mg (1 time daily) • Propranolol 80mg (1 time daily) • Tri-Sprintec (1 time daily) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Inderal LA 80mg (1 time daily) • Propranolol 20mg (1 time daily) • Wal-tin Loratadine 10mg (1 time daily) • Propranolol 80mg (1 time daily) • Tri-Sprintec (1 time daily)		

	Medication Administration Records did not contain the dosage for the following medications: • Tri-Sprintec (1 time daily) Medication Administration Records did not contain the route of administration for the following medications: • Tri-Sprintec (1 time daily) Individual #10 September 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Risperdal 1mg (1 time daily) • Sertraline 100mg (1 time daily) October 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Risperdal 1mg (1 time daily) • Sertraline 100mg (1 time daily) November 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Risperdal 1mg (1 time daily) • Sertraline 100mg (1 time daily) October 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Risperdal 1mg (1 time daily) • Sertraline 100mg (1 time daily)		

	Individual #16 September 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Lisinopril 10mg (1 time daily) • Triamcindone 0.1% (2 times daily) • Benzadin (2 times daily) • Depakote 500mg (1 time daily) • Clominpramine (1 time daily) Medication Administration Records did not contain the dosage for the following medications: • Benzadin • Clominpramine Medication Administration Records did not contain the route of administration for the following medications: • Benzadin (2 times daily) • Depakote 500mg (1 time daily) • Clominpramine (1 time daily) Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Depakote 500mg (1 time daily) – Blank 09/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 & 20 (9PM) • Clomipramine (1 time daily) – Blank 09/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 & 28 (9PM)		

	October 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Fluoxetine 20mg (1 time daily) – Blank 10/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (9AM) Medication Administration Records did not indicate the dosage administered: • Clomipramine 50mg (2 - 3 capsules 1 time daily) - 10/01, 02, 03, 04, 05, 06, 07, 08, 09, 10 & 11 • Depakote 500mg (1 - 4 capsules 1 time daily) - 10/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16 & 17 • Clomipramine 25mg (1 - 4 capsules 1 time daily) - 10/01, 02, 03, 04, 05, 06, 07, 08, 09 & 10 November 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Cefuroxime 500mg (2 times daily) Medication Administration Records did not indicate the dosage administered: • Clomipramine 50mg (2 - 3 capsules 1 time daily) - 11/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 • Depakote 500mg (2 - 3 capsules 1 time daily) - 11/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 • Clomipramine 25mg (1 - 4 capsules 1 time		

	daily) - 11/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 Individual #17 October 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Ethosuximide 250mg (2 times daily) – Blank 10/31 (8AM) 10/30 & 31 (10PM) • Oyst-Cal 500mg (2 times daily) - Blank 10/31 (8AM) 10/30 & 31 (10PM) • Vitamin D 400u (1 time daily) - Blank 10/31 (8AM) • Phenobarbital 47.2mg (1 time daily) - Blank 10/30 & 31 (10PM) Individual #18 September 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Calcium Citrate + D (2 times daily) – Blank 09/14 & 16 (7AM) • Multivitamin (1 time daily) - Blank 09/01, 02, 03, 04, 10, 14 & 16 (7AM) • Keta Conzole Shampoo (2 times week) - Blank 09/01, 08 & 29 (Tuesday) 09/03, 10 & 24 (Thursday) • Baclofen 10mg (3 times daily) - Blank 09/14 & 16 (7AM) & 09/09, 10, 11 & 12 (Noon) • Boost Drink (1 time daily) - Blank 09/04, 07, 09, 14, 16, 21, 22, 25, 18, 29 & 30		

	October 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Keta Conzole Shampoo (2 times week) - Blank 10/13 & 20 ("Tuesday") 09/15 & 22 ("Thursday") • Boost Drink (1 time daily) - Blank 10/27 November 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Keta Conzole Shampoo (2 times week) - Blank 11/12 ("Thursday") Individual #23 September 2009 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Metformin HCL 1000mg (2 times daily) • Glyburide 5mg (2 times daily) • Levothyroxine 0.1mg (1time daily) • Pioglitazone 30mg (1 time daily) • Simvastastin 20mg (1 time daily) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Metformin HCL 1000mg (2 times daily) • Glyburide 5mg (2 times daily) • Levothyroxine 0.1mg (1time daily) • Pioglitazone 30mg (1 time daily)		

	• Simvastastin 20mg (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: • Metformin HCL 1000mg (2 times daily) • Glyburide 5mg (2 times daily) • Levothyroxine 0.1mg (1time daily) • Pioglitazone 30mg (1 time daily) • Simvastastin 20mg (1 time daily) October 2009 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Metformin HCL 1000mg (2 times daily) • Glyburide 5mg (2 times daily) • Levothyroxine 0.1mg (1time daily) • Pioglitazone 30mg (1 time daily) • Simvastastin 20mg (1 time daily) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Metformin HCL 1000mg (2 times daily) • Glyburide 5mg (2 times daily) • Levothyroxine 0.1mg (1time daily) • Pioglitazone 30mg (1 time daily)		

	• Simvastastin 20mg (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: • Metformin HCL 1000mg (2 times daily) • Glyburide 5mg (2 times daily) • Levothyroxine 0.1mg (1time daily) • Pioglitazone 30mg (1 time daily) • Simvastastin 20mg (1 time daily) November 2009 During on-site survey Medication Administration Records were requested for month of November 2009. As of January 11, 2009, Medication Administration Records had not been provided. Individual #24 October 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Tegretol 14ml (3 times daily) - Blank 10/09 (2PM) 10/09 ("Bedtime") November 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Tegretol 14ml (3 times daily) - Blank 11/02, 02, 05, 06, 08, 09, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 24, 25, 26, 28, 29, 30 & 31 (7AM) 11/04, 05, 06, 07, 08, 09, 10, 11, 13, 14, 15, 17, 18, 21, 22, 24, 25, 26, 28, 29, 30 & 31 (2PM) 11/01, 02, 03, 04, 05, 06, 07, 08, 09, 10,		

	11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 25, 26, 27, 28, 29, 30 & 31 (“Bedtime”)		

Tag # 1A09 Medication Delivery - PRN Medication	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 11 of 19 Individuals. Individual #1 November 2009 Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard, such as no Physician's Orders were found for the following medications, the diagnosis for which the medication is prescribed, the route of administration for the following medications : • Comtrex Cold Pill Individual #3 September 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Tylenol 325mg or 500mg (PRN) Medication Administration Records did not indicate the dosage administered: • Tylenol 325mg or 500mg – PRN – 09/29 & 30 (given 1 time daily) October 2009 Medication Administration Records did not indicate the dosage administered: • Tylenol 325mg or 500mg – PRN – 10/12 & 31 (given 1 time daily) Individual #5 November 2009 Medication Administration Records did not contain the dosage for the following medications:		

(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued	• Amoxicillin Individual #9 September 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Maxalt 10mg (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Maxalt 10mg (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Maxalt 10mg – PRN – 09/04 & 09/14 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Maxalt 10mg – PRN – 09/04 & 09/14 (given 1 time daily) October 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Maxalt 10mg (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Maxalt 10mg (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Maxalt 10mg – PRN – 10/08 & 13 (given 1 time daily)		

or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period. **Department of Health** **Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006** **F. PRN Medication** 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.	No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Maxalt 10mg – PRN – 10/08 & 13 (given 1 time daily) November 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Maxalt 10mg (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Maxalt 10mg (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Maxalt 10mg – PRN – 11/16 & 28 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Maxalt 10mg – PRN – 11/16 & 28 (given 1 time daily) Individual #10 September 2009 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Citrucel OTC (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Citrucel OTC – PRN – 09/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18,		

4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention.	19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Citrucel OTC – PRN – 09/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times daily) October 2009 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Citrucel OTC (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Citrucel OTC – PRN – 10/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times daily) 10/15 & 20 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Citrucel OTC – PRN – 10/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times daily) 10/15 & 20 (given 1 time daily) November 2009 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Citrucel OTC (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:		

(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.).	• Citrucel OTC – PRN – 11/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18. 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Citrucel OTC – PRN – 11/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18. 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 2 times daily) Individual #12 September 2009 The following Medications were not documented on the Medication Administration Records. Per Family Living Provider, medication is given up to 2 times weekly as needed: • Enema No Physician's Orders were found for the following medications. Per Family Living Provider, medication is given up to 2 times weekly as needed: • Enema October 2009 The following Medications were not documented on the Medication Administration Records. Per Family Living Provider, medication is given up to 2 times weekly as needed: • Enema No Physician's Orders were found for the following medications. Per Family Living Provider, medication is given up to 2 times weekly as needed: • Enema November 2009 The following Medications were not documented		

	on the Medication Administration Records. Per Family Living Provider, medication is given up to 2 times weekly as needed: • Enema No Physician's Orders were found for the following medications. Per Family Living Provider, medication is given up to 2 times weekly as needed: • Enema Individual #16 September 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Lorazepam 1mg (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Lorazepam – PRN – 09/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 13, 14, 16, 17, 18, 19, 20., 21, 22, 23, 25, 26, 28, 29 & 30 (given up to 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Lorazepam – PRN – 09/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 13, 14, 16, 17, 18, 19, 20., 21, 22, 23, 25, 26, 28, 29 & 30 (given up to 1 time daily) October 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Lorazepam 1mg (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the		

	following PRN medication: • Lorazepam – PRN – 10/28 (given 1 time(s) daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Lorazepam – PRN – 10/28 (given up to 1 time daily) November 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Lorazepam 1mg (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Lorazepam – PRN – 10/02 & 10 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Lorazepam – PRN – 10/02 & 10 (given 1 time daily) Individual #17 September 2009 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Claritin Redittabs 10mg – PRN – 0902 & 03 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Claritin Redittabs 10mg – PRN – 0902 & 03 (given 1 time daily)		

	Individual #19 September 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Ibuprofen 800mg (PRN) • Tylenol 325mg (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 800mg – PRN – 09/06, 07 & 08 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 800mg – PRN – 09/06, 07 & 08 (given 1 time daily) October 2009 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 800mg – PRN – 10/26 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 800mg – PRN – 10/18, 19 & 26 (given 1 time daily) Individual #20 September 2009 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Fluticasone Nasal Spray 0.05% – PRN – 09/08 &11 (given 1 time daily)		

	• Ventolin HFA Inhaler - PRN - 09/14 & 19 (given 1 time daily) 09/22 (given 2 times daily) • Tylenol 325mg or 500mg - PRN - 09/07, 10, 12, 18 & 21 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Fluticasone Nasal Spray – PRN – 09/08 &11 (given 1 time daily) • Ventolin HFA Inhaler - PRN - 09/14 & 19 (given 1 time daily) 09/22 (given 2 times daily) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Tylenol 325mg or 500mg (PRN) October 2009 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Fluticasone Nasal Spray 0.05% – PRN – 10/12 & 17 (given 1 time daily) • Albuterol HFA Inhaler - PRN - 10/10 (given 1 time daily) • Ibuprofen 800mg - PRN - 10/18 (given 1 time daily) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Fluticasone Nasal Spray – PRN – 09/08 &11 (given 1 time daily) • Ventolin HFA Inhaler - PRN - 09/14 & 19 (given 1 time daily) 09/22 (given 2 times daily)		

	Individual # 24 September 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Tylenol 325mg/500mg (PRN) • Pepto Bismol (PRN) • Ibuprofen 20ml/40ml (PRN) October 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Tylenol 325mg/500mg (PRN) • Pepto Bismol (PRN) • Ibuprofen 20ml/40ml (PRN) November 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Tylenol 325mg/500mg (PRN) • Pepto Bismol (PRN) • Ibuprofen 20ml/40ml (PRN)		

Tag # 1A09 Medication Delivery - PRN Nurse Approval	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. **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	Based on interview, the Agency failed to maintain documentation of PRN usage as required by standard. When asked if DSP, including Family Living Providers, needed to contact the Agency Nurse prior to administering/assisting individuals with PRN Medications, the following was reported: • #302 stated, "Family Living Providers, whether related or surrogate, are not made to contact the nurse prior to administration of PRN Medications. They use the standing orders and call the PCP if needed."		

assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual. 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the 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.). **NMAC 16.19.11.8 MINIMUM STANDARDS:** **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications.			

Tag # 1A11 (CoP) Transportation Training	Scope and Severity Rating: D		
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… **Department of Health (DOH)** **Developmental Disabilities Supports Division (DDSD) Policy** Training Requirements for Direct Service Agency Staff Policy **Eff Date:** March 1, 2007 **II. POLICY STATEMENTS:** 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	Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 22 of 261 Direct Service Personnel. No documented evidence was found of the following required training: • Transportation (DSP #58, 78, 87, 95, 121, 123, 138, 189, 199, 227, 230, 237, 241 & 265) **When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported:** • DSP #47 stated, "No." • DSP #60 stated, "No training." • DSP #149 stated, "Not yet." • DSP #170 stated, "No, I don't think so." • DSP #172 stated, "Not through Su Vida but I took the State's Defensive Driving Class a long time ago." • DSP #191 stated, "My insurance on my car is checked but I'm not trained." • DSP #227 stated, "No." • DSP #234 stated, "Nothing other then safety training with my other job." • DSP #266 stated, "No."		

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		
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 7 of 24 individuals. Individual #1 September 2009 • The Agency billed 30 units of Family Living Services from 09/01/2009 through 09/30/2009. Documentation did not contain start and end time to justify billing. October 2009 • The Agency billed 31 units of Family Living Services from 10/01/2009 through 10/31/2009. Documentation did not contain start and end time to justify billing. November 2009 • The Agency billed 30 units of Family Living Services from 11/01/2009 through 11/30/2009. Documentation did not contain start and end time to justify billing. Individual #2 September 2009 • The Agency billed 30 units of Family Living Services from 09/01/2009 through 09/30/2009. Documentation did not contain start and end time to justify billing. October 2009 • The Agency billed 31 units of Family Living Services from 10/01/2009 through 10/31/2009. Documentation did not contain start and end time to justify billing. November 2009 • The Agency billed 30 units of Family Living Services from 11/01/2009 through 11/30/2009. Documentation did not contain start and end		

	time to justify billing. Individual #4 September 2009 • The Agency billed 30 units of Family Living Services from 09/01/2009 through 09/30/2009. Documentation did not contain start and end time to justify billing. October 2009 • The Agency billed 31 units of Family Living Services from 10/01/2009 through 10/31/2009. Documentation did not contain start and end time to justify billing. November 2009 • The Agency billed 30 units of Family Living Services from 11/01/2009 through 11/30/2009. Documentation did not contain start and end time to justify billing. Individual #12 September 2009 • The Agency billed 24 units of Family Living Services from 09/01/2009 through 09/24/2009. Documentation did not contain start and end time to justify billing. October 2009 • The Agency billed 31 units of Family Living Services from 10/01/2009 through 10/31/2009. Documentation did not contain start and end time to justify billing. November 2009 • The Agency billed 20 units of Family Living Services from 11/01/2009 through 11/20/2009. Documentation did not contain start and end time to justify billing. • The Agency billed 8 units of Family Living Services from 11/23/2009 through 11/30/2009.		

	Documentation did not contain start and end time to justify billing. Individual #15 September 2009 • The Agency billed 11 units of Family Living Services from 09/01/2009 through 09/11/2009. Documentation did not contain start and end time to justify billing. • The Agency billed 13 units of Family Living Services from 09/18/2009 through 09/30/2009. Documentation did not contain start and end time to justify billing. October 2009 • The Agency billed 31 units of Family Living Services from 10/01/2009 through 10/31/2009. Documentation did not contain start and end time to justify billing. • The Agency billed 656 units of Adult Habilitation from 11/01/2009 through 11/30/2009. Documentation on 10/21/2009, 10/27/2009 & 10/28/2009 did not contain start and end time to justify billing. November 2009 • The Agency billed 30 units of Family Living Services from 11/01/2009 through 11/30/2009. Documentation did not contain start and end time to justify billing. Individual #16 September 2009 • The Agency billed 30 units of Family Living Services from 09/01/2009 through 09/30/2009. Documentation did not contain start and end time to justify billing. October 2009 • The Agency billed 31 units of Family Living		

	Services from 10/01/2009 through 10/31/2009. Documentation did not contain start and end time to justify billing. November 2009 • The Agency billed 30 units of Family Living Services from 11/01/2009 through 11/30/2009. Documentation did not contain start and end time to justify billing. Individual #24 September 2009 • The Agency billed 30 units of Family Living Services from 09/01/2009 through 09/30/2009. Documentation did not contain start and end time to justify billing. October 2009 • The Agency billed 31 units of Family Living Services from 10/01/2009 through 10/31/2009. Documentation did not contain start and end time to justify billing. November 2009 • The Agency billed 30 units of Family Living Services from 11/01/2009 through 11/30/2009. Documentation did not contain start and end time to justify billing.		

Tag # 1A15 Nurse Availability	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. **NEW MEXICO NURSING PRACTICE ACT CHAPTER 61, ARTICLE 3** I. "licensed practical nursing" means the practice of a directed scope of nursing requiring basic knowledge of the biological, physical, social and behavioral sciences and nursing procedures, which practice is at the direction of a registered nurse, physician or dentist licensed to practice in this state. This practice includes but is not limited to: (1) contributing to the assessment of the health status of individuals, families and communities; (2) participating in the development and modification of the plan of care; (3) implementing appropriate aspects of the plan of care commensurate with education and verified competence; (4) collaborating with other health care professionals in the management of health care; and (5) participating in the evaluation of responses to interventions;	Based on interview, the Agency failed to ensure nursing services were available as needed for 5 of 24 individuals. **When DSP were asked about the availability of their agency nurse, the following was reported:** • DSP #89 stated, "The nurse is not proactive. I've never met the nurse." (Individual # 3) • DSP #259 stated, "There is a nurse at the office that I could call but she never sees (Individual #12). She hasn't seen him since we started with the agency in 2006." (Individual #12) • DSP # 109 stated, "I don't know." (Individual #13 &14) • DSP #60 stated, "I don't know." (Individual #24)		

Tag # 1A15 Healthcare Documentation	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	Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 2 of 24 individual The following were not found, incomplete and/or not current: • **Special Health Care Needs:** • Nutritional Plan ° Individual #15 - As indicated by the IST section of ISP the individual is required to have a plan. ° Individual #17 - As indicated by the IST section of ISP the individual is required to have a plan.		

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

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

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

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE** **PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **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	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 169 of 261 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 #40, 78, 86, 92, 101, 110, 117, 121, 124, 140, 150, 164, 169, 173, 189, 194, 198, 208, 222, 224, 229, 230, 237, 253, 254, 264, 270, 272, 273, 275, 278, 280, 286, 297, 298 & 299) • Basic Health/Orientation (DSP #40, 42, 76, 77, 78, 79, 92, 101, 108, 110, 121, 124, 140, 149, 150, 160, 173, 183, 189, 194, 198, 208, 218, 222, 224, 228, 229, 230, 237, 250, 252, 253, 254, 270, 272, 273, 275, 278, 286, 297, 298 & 299) • Person-Centered Planning (1-Day) (DSP #40, 42, 65, 73, 77, 78, 81, 83, 86, 89, 92, 96, 101, 103, 110, 121, 127, 140, 143, 149, 150, 161, 163, 164, 173, 174, 186, 189, 194, 201, 204, 205, 208, 216, 218, 222, 230, 235, 237, 239, 253, 254, 264, 270, 272, 273, 278, 286, 298, 299 & 300) • First Aid (DSP #42, 48, 48, 50, 74, 78, 85, 93, 100, 101, 102, 105, 118, 128, 130, 131, 133, 134, 142, 149, 167, 189, 196, 197, 198, 204, 208, 213, 214, 225, 228, 230, 243, 244, 253, 264, 265, 267, 268, 269, 270, 281, 289, 295 & 300) • CPR (DSP #42, 43, 44, 48, 50, 52, 54, 58, 59, 63, 74, 76, 78, 79, 80, 84, 88, 91, 95, 100, 101, 102, 105, 116, 118, 119, 122, 125, 128, 129, 133, 134, 141, 149, 152, 154, 155, 159, 168,		

accordance with the specifications described in the 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.	169, 171, 174, 182, 189, 196, 197, 200, 201, 204, 208, 213, 214, 217, 225, 228, 230, 231, 232, 233, 236, 243, 249, 253, 262, 264, 265, 267, 268, 269, 270, 281, 282, 289, 296 & 300) • Assisting With Medication Delivery (DSP #41, 42, 52, 62, 64, 73, 78, 81, 82, 83, 90, 91, 92, 93, 100, 102, 103, 117, 121, 127, 133, 135, 140, 146, 149, 150, 151, 171, 177, 185, 189, 190, 194, 195, 196, 198, 199, 201, 203, 204, 208, 209, 211, 212, 213, 214, 217, 219, 230, 235, 237, 241, 242, 244, 246, 247, 249, 250, 253, 254, 257, 258, 262, 264, 267, 270, 273, 277, 278, 279, 286, 293, 296, 298 & 299) • Participatory Communication & Choice Making (DSP #57, 61, 62, 84, 85, 94, 121, 142, 159, 175, 205, 212, 266, 267, 277, 286 & 294) • Rights & Advocacy (DSP #84, 95, 121, 205, 212, 267, 283 & 286) • Level 1 Health (DSP #121, 126, 205, 283 & 286) • Positive Behavior Supports Strategies (DSP #62, 69, 83, 85, 121, 143, 147, 203, 205, 207, 231, 260, 283, 286 & 294) • Teaching & Support Strategies (DSP #68, 83, 121, 142, 170, 174, 201, 204, 205, 233, 235, 266, 283 & 286)		

Tag # 1A22 Staff Competence	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **F. Qualifications for Direct Service Personnel:** The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency: (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy	Based on interview, the Agency failed to ensure that training competencies were met for 17 of 33 Direct Service Personnel. **When DSP were asked if they attended the Individual's Annual ISP meeting or if they are unable to attend if they are able to give input, the following was reported:** • DSP #49 stated, "No." (Individual #3) **When DSP were asked if they received training on the Individual's ISP and what the plan covered, the following was reported:** • DSP #109 stated, "No, but I'm related to him." (Individual #13) • DSP #109 stated, "No, but I'm related to her, so I know her problems." (Individual #14) **When DSP were asked if they received training on the Individual's Positive Behavioral Supports Plan and what the plan covered, the following was reported:** • DSP #60 stated, "She has a plan but I don't know what it covers." According to the Agency file, the Individual requires a Positive Behavioral Supports Plan. (Individual #24) • DSP #109 stated, "Just what I heard at the ISP." According to the Agency file, the Individual requires a Positive Behavioral Supports Plan. (Individual #14) • DSP #234 stated, "I don't know what they work on, I'm not with them when they met." According to the Agency file, the Individual requires a Positive Behavioral Supports Plan. (Individual #19)		

Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and (5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support. (6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows: (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.	• DSP # 306 stated, "No, not yet." According to the Agency file, the Individual requires a Positive Behavioral Supports Plan. (Individual #16) **When DSP were asked if the individual had a Positive Behavioral Crisis Plan and what the plan covered, the following was reported:** • DSP #215 stated, "I don't know." According to Agency file, the Individual requires a Positive Behavioral Supports Crisis Plan. (Individual #8) **When DSP were asked if the Individual had a Speech Therapy Plan and what the plan covered, the following was reported:** • DSP #109 stated, "Yes but I haven't received training on it." According to the ISP, the individual requires a Speech Therapy Plan. (Individual #14) • DSP #122 stated, "Yes, but I don't know what it covers." According to the ISP, the Individual requires a Speech Therapy Plan. (Individual #4) • DSP #178 stated, "No, I'm not sure of that." According to the ISP, the Individual requires a Speech Therapy Plan. (Individual #11) • DSP #215 stated, "I don't know what therapist she has. I think she has this but I don't know what the plan covers because I'm not really involved with those things at all." According to the ISP, the Individual requires a Speech Therapy Plan. (Individual #9) • DSP #234 stated, "I haven't been trained." According to the ISP, the individual requires a Speech Therapy Plan. (Individual #19) **When DSP were asked if the Individual had an**		

	Occupational Therapy Plan and what the plan covered, the following was reported: • DSP #212 stated, "I'm not sure." According to the ISP, the individual requires an Occupational Therapy Plan. (Individual #18) • DSP #215 stated, "I don't know what therapist she has. I don't know what the plan covers because I'm not really involved with those things at all." According to the ISP, the Individual requires an Occupational Therapy Plan. (Individual #9) **When DSP were asked if they received training on the Individual's Physical Therapy Plan and what the plan covered, the following was reported:** • DSP #212 stated, "I'm not sure." According to the ISP, the individual requires a Physical Therapy Plan. (Individual #18) • DSP #215 stated, "I don't know what therapist she has. I think she has this but I don't know what the plan covers because I'm not really involved with those things at all." According to the ISP, the Individual requires a Physical Therapy Plan. (Individual #9) **When DSP were asked if the Individual had any Health Care Plans and what the plan covered, the following was reported:** • DSP #49 stated, "I'm not aware of any health issues that would require Health Care Plans." As indicated by the Agency file, the Individual has Health Care Plans for Seizures, High Blood Pressure & High Cholesterol. (Individual #3) • DSP #109 stated, "I don't think so. The RN didn't train me." As indicated by the Agency file, the		

	Individual has a Health Care Plan for Diabetes. (Individual #14) • DSP #170 stated, "No, he doesn't have one." As indicated by the Agency file, the Individual has a Health Care Plan for seizures. (Individual #1) • DSP #212 stated, "I think so but I don't know what for." As indicated by the Agency file, the Individual has a Health Care Plan for Seizures. (Individual #18) • DSP #215 stated, "No, she doesn't have any." As indicated by the Agency file, the Individual has Health Care Plans for Seizures & Migraines. (Individual #9) • DSP #234 stated, "Yes for behaviors so he doesn't escalate." As indicated by the Agency file, the Individual has Health Care Plan for Hypertension, Hyperlipdemia, and Benign Prostatic Hyperplasia & GERD. (Individual #19) **When DSP were asked the Individual had any Crisis Plans and what the plan covered, the following was reported:** • DSP #60 stated, "I don't know." As Indicated by the Individual Specific Training Section of the ISP, the Individual also has Crisis Plans for Aspiration & Seizures. (Individual #24) • DSP #122 stated, "I'm not sure." As indicated by the Individual Specific Training Section of the ISP, the Individual has a Crisis Plan for seizures. (Individual #4) • DSP #137 stated, "No." As indicated by the Agency File, the individual has Crisis Plans for Aspiration and a Cardiac/heart Condition. (Individual #5)		

	• DSP #162 stated, "Yes, for Seizures." As Indicated by the Individual Specific Training Section of the ISP, the Individual also has a Crisis Plan for Aspiration. (Individual #24) • DSP #170 stated, "No." As indicated by the Individual Specific Training Section of the ISP, the Individual has a Crisis Plan for seizures. (Individual #1) • DSP #215 stated, "No." As Indicated by the Individual Specific Training Section of the ISP, the Individual has a Crisis Plan for Seizures. (Individual # 9) **When DSP were asked to describe what to do if the individual has a seizure and if there was a person-specific seizure plan/crisis plan, the following was reported:** • DSP #170 stated, "No, no plan. They don't even have a seizure protocol that I'm aware of." According to documents reviewed, the Individual has a seizure Health Care Plan and Seizure Crisis Plan. (Individual #1) • DSP #212 stated, "Yes, but I haven't received any client specific training." (Individual #18) • DSP #306 stated, "He just has a history of seizures. There is no person-specific seizure plan or crisis plan." According to the Agency file, the Individual has a Seizure Protocol. (Individual #17) **When DSP were asked if the individual had any bowel and/or bladder issues, if bowel movements were tracked, if fluid intake/output was tracked and if the nurse was notified if the individual did not have a bowel movement within a certain amount of time, the following was reported:**		

	• DSP #259 stated, "Yes he does. He gets an Enema on Wednesdays or Saturdays if needed. This is not prescribed it is just over the counter. I don't call the nurse at all, I'd call the PCP if needed and I don't track his fluid intake and output." (Individual #12) **When DSP were asked if they assisted the individual with medications and had received the Assisting with Medication Delivery (AWMD) training, the following was reported:** • DSP #234 stated, "Yes, but I haven't been trained. Had to reschedule the training." (Individual #19) **When DSP were asked, what are the steps did they need to take before assisting an individual with PRN medication, the following was reported:** • DSP #170 stated, "I don't remember what to do." According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. (Individual #1) • DSP #178 stated, "I'd make sure the doctor has signed of on it, wash my hands and ensure privacy." According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according		

	to instructions given by the ordering PCP. (Individual #11) • DSP #212 stated, "I wouldn't need to call the nurse." According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. (Individual #18) • DSP #215 stated, "I don't give medication at all. I guess I would call her parent or guardian to give them." According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. (Individual #9) • DSP #259 stated, "There's not any steps...I would just note it on the MAR." According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. (Individual #12) • DSP #293 stated, "I'd write it in the book and give her the med." According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting		

	with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. (Individual #17) • DSP #294 stated, "I don't need to call the nurse to give a PRN." According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. (Individual #18) **When DSP were asked, what to do if there is a medication error, the following was reported:** • DSP #47 stated, "I'd call the Doctor for another med." (Individual #2) Per Agency Policy SS 1.15 "X. Contaminated/Refused/Discontinued Medications: all medications that are discontinued, refused or contaminated must be destroyed. Staff will: A. Place medication needed to be destroyed will be in a sealed bag. B. Labeled appropriately…NOTE: SVS staff should never destroy a medication themselves." • DSP #122 stated, "I'd throw away the pill that fell." (individual #4) Per Agency Policy SS 1.15 "X. Contaminated/Refused/Discontinued Medications: all medications that are discontinued, refused or contaminated must be destroyed. Staff will: A. Place medication needed to be destroyed will be in a sealed bag. B. Labeled appropriately…NOTE: SVS staff should never destroy a medication themselves." **When DSP were asked what the individual's Diagnosis were, the following was reported:**		

	• DSP #109 stated, "I don't what he has, things just aren't right." According to the individuals ISP he is diagnosed with Mental Retardation. Staff did not discuss the listed diagnosis. (Individual #13) **When DSP were asked if the Individual had any food and/or medication allergies, the following was reported:** • DSP #60 stated, "Just hives." As indicated by documentation reviewed, Individual has an medication allergy to Vancomycin." (Individual #24) **When DSP were asked if they had been trained on transferring and positioning of the Individual, the following was reported:** • DSP #60 stated, "No I haven't been trained" Individual requires support to be transferred and positioned. (Individual #24) • DSP #286 stated, "No, I haven't been trained." Individual requires full support to be transferred and positioned. (Individual #22)		

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D		
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	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 6 of 269 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** • #40 – Date of hire 09/07/2009 • #132 – Date of hire 12/06/2002 • #176 – Date of hire 09/01/2009 • #206 – Date of hire 11/14/2007 • #237 – Date of hire 08/03/2009 • #250 – Date of hire 05/20/2009		

any of the felonies in this subsection. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1.IV. General Provider Requirements.** **D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.			

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E		
NMAC 7.1.12.8 **REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED**: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.	Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 61 of 269 Agency Personnel. **The following Agency personnel records contained NO evidence of the Employee Abuse Registry being completed:** • #53 – Date of hire 01/08/2007 • #69 – Date of hire 06/29/2007 • #78 – Date of hire 09/01/2009 • #83 – Date of hire 10/09/2007 • #91 – Date of hire 02/01/2006 • #93 – Date of hire 06/26/2006 • #110 – Date of hire 09/01/2009 • #165 – Date of hire 05/01/2006 • #187 – Date of hire 10/01/2009 • #190 – Date of hire 09/01/2009 • #201 – Date of hire 04/17/2009 • #285 – Date of hire 07/17/2006 **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** • #42 – Date of hire 09/01/2009 • #46 – Date of hire 04/04/2007 • #50 – Date of hire 09/01/2009 • #51 – Date of hire 05/12/2009 • #61 – Date of hire 02/25/2008 • #63 – Date of hire 03/24/2008 • #64 – Date of hire 07/13/2006 • #65 – Date of hire 09/01/2009 • #71 – Date of hire 09/01/2009 • #73 – Date of hire 10/01/2009 • #74 – Date of hire 10/01/2009 • #84 – Date of hire 08/25/2006 • #89 – Date of hire 09/02/2009		

E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1.IV. General Provider Requirements.** **D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.	• #90 – Date of hire 03/28/2006 • #92 – Date of hire 09/01/2009 • #101 – Date of hire 09/01/2009 • #112 – Date of hire 11/10/2009 • #121 – Date of hire 03/10/2008 • #127 – Date of hire 09/01/2009 • #140 – Date of hire 08/27/2009 • #149 – Date of hire 09/01/2009 • #150 – Date of hire 01/28/2009 • #152 – Date of hire 05/30/2006 • #172 – Date of hire 06/01/2007 • #184 – Date of hire 09/01/2009 • #186 – Date of hire 09/01/2009 • #189 – Date of hire 09/01/2009 • #194 – Date of hire 09/01/2009 • #196 – Date of hire 09/15/2009 • #197 – Date of hire 02/07/2009 • #199 – Date of hire 08/26/2009 • #206 – Date of hire 11/14/2007 • #209 – Date of hire 03/10/2006 • #218 – Date of hire 09/01/2009 • #219 – Date of hire 09/01/2009 • #225 – Date of hire 09/01/2009 • #230 – Date of hire 10/06/2009 • #241 – Date of hire 06/01/2006 • #253 – Date of hire 08/26/2009 • #254 – Date of hire 09/01/2009 • #258 – Date of hire 05/06/2007 • #266 – Date of hire 01/01/2008 • #267 – Date of hire 07/20/2006 • #271 – Date of hire 09/01/2009 • #281 – Date of hire 09/01/2009 • #286 – Date of hire 07/01/2008 • #296 – Date of hire 10/03/2006 • #300 – Date of hire 03/01/2007 • #301 – Date of hire 03/27/2006		

Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: E		
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 and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 49 of 269 Agency Personnel. • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#78, 87, 98, 102, 107, 126, 134, 138, 139, 142, 144, 156, 160, 162, 165, 167, 168, 170, 180, 188, 189, 191, 192, 202, 212, 217, 227, 230, 233, 235, 237, 245, 246, 247, 251, 263, 280, 281, 283, 286, 287, 288, 293, 296 & 308) **When DSP were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect & Misappropriation of Consumers' Property, the following was reported:** • DSP #122 stated, "Su Vida, CYFD and APS." DSP failed to mention The Department of Health/Division of Health Improvement. • DSP #293 stated, "I don't know." • DSP #149 stated, "Su Vida then my supervisor." • DSP #156 stated, "I'd call the caseworker and Su Vida." **When DSP were asked to give examples of Abuse, Neglect & Misappropriation of Consumers' Property, the following was reported:** • DSP #149 stated, "I don't know any examples of exploitation." • DSP #60 stated, "I don't know exploitation."		

Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: F		
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] **Long Term Services Division** **Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003** **IV. POLICY STATEMENT -** Human Rights Committees are required for residential service provider agencies. The purpose of these	Based on record review, the Agency failed to follow DDSD Policy regarding Human Rights Committee Requirements. When asked if the Agency had a Human Rights Committee or was part of a Regional HRC and how often they met the following was reported: • #311 stated, "Yes we currently have our own HRC and meet quarterly. However, not every individual is reviewed quarterly, but they are reviewed at least annually." Per DDSD Policy, Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly.		

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

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

Tag # 1A33 Board of Pharmacy - Med Storage	Scope and Severity Rating: B		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **E. Medication Storage:** 1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee. 2. Drugs to be taken by mouth will be separate from all other dosage forms. 3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature. 4. Separate compartments are required for each resident's medication. 5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day. 6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist. **8. References** A. Adequate drug references shall be available for facility staff **H. Controlled Substances (Perpetual Count Requirement)** 1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance, indicating the following information: a. date b. time administered c. name of patient	Based on record review and observation, the Agency failed to ensure proper storage of medication for 4 of 19 individuals. Observation included: Individual #9 • Medications were not kept in a locked compartment, as per Agency Policy. Individual #18 • Ketoconazole 2% Shampoo. Drugs to be taken by mouth will be separate from all other dosage forms. This medication is not kept separate from oral medications, as required by regulation. • Observation by surveyors found a loose half pill in Medication Box. When DSP in the home during the on-site visit was asked about the medication they reported, they were not sure what medication was but said may be part of a Multi-Vitamin. Individual #21 • Medications were not kept in a locked compartment, as per Agency Policy. • Ferrous Sulfate 324mg expired 03/31/2008. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Naproxen 500mg expired 08/08/2007. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Hydroco/APAP 325mg expired 04/30/2008. Expired medication was not kept separate from		

d. dose e. practitioner's name f. signature of person administering or assisting with the administration the dose g. balance of controlled substance remaining.	other medications as required by Board of Pharmacy Procedures. • Neo/Poly/Dex 0.1% expired 10/11/2009. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. Individual #24 • Ibuprofen expired 12/02/2009. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Ibuprofen expired 09/29/2009. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Acetaminophen expired 09/29/2009. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Ibuprofen expired 04//28/2009. Expired medication was not kept separate from other medications as required by the Board of Pharmacy Procedures. • Observation by surveyors found the Individual had Tegretol in an unmarked bottle. It was reported by DSP #162 it was kept this way for easier use with a syringe. It was additionally reported the original Bottle with Medication label attached was thrown away.		

Tag # 1A36 SC Training	Scope and Severity Rating: B		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training **Requirements for** Direct Support Staff and **Internal Service Coordinators** Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 2 of 8 Service Coordinators. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed: • Pre-Service Manual (SC #303) • Promoting Effective Teamwork (SC #301)		

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (2) **Individual-specific training** for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** **A.** Individuals shall receive services from competent and qualified staff. **B.** Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.	Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 157 of 269 Agency Personnel. Review of personnel records found no evidence of the following: • Individual Specific Training (#40, 41, 42, 45, 48, 49, 50, 51, 52, 53, 55, 56, 57, 58, 59, 60, 61, 63, 65, 66, 67, 68, 69, 72, 73, 74, 75, 77, 78, 79, 81, 85, 86, 88, 92, 93, 95, 96, 97, 98, 100, 101, 103, 104, 105, 109, 110, 111, 112, 113, 114, 117, 118, 120, 121, 124, 136, 138, 139, 140, 141, 145, 147, 149, 150, 151, 152, 154, 163, 164, 166, 169, 173, 176, 182, 184, 186, 187, 188, 189, 190, 192, 193, 194, 196, 197, 198, 199, 200, 201, 203, 205, 206, 207, 208, 209, 210, 212, 213, 214, 216, 218, 219, 220, 221, 222, 223, 224, 225, 228, 229, 230, 233, 235, 236, 237, 238, 239, 241, 244, 246, 247, 248, 249, 250, 251, 253, 254, 255, 256, 260, 264, 266, 267, 269, 270, 271, 272, 273, 275, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 288, 291, 292, 297, 298, 299 & 306)		

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Scope and Severity Rating: A		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **E. Provider Agency Reporting Requirements:** All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD.	Based on record review, the Agency failed to complete quarterly reports as required for 1 of 24 individuals receiving Community Inclusion services. **Adult Habilitation Quarterly Reports** • Individual #15 - None found for 10/2008 - 12/2008		

Tag # 5I44 AH Reimbursement	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 4 of 12 individuals. Individual #1 October 2009 • The Agency billed 415 units of Family Living from 10/01/2009 through 10/30/2009. Documentation received accounted for 413 units. November 2009 • The Agency billed 269 units of Family Living from 11/01/2009 through 11/30/2009. Documentation received accounted for 265 units. Individual #7 October 2009 • The Agency billed 622 units of Adult Habilitation from 10/01/2009 through 10/26/2009. Documentation received accounted for 618 units. Individual #12 November 2009 • The Agency billed 590 units of Adult Habilitation from 11/02/2009 through 11/30/2009. Documentation received accounted for 542 units. Individual #15 September 2009 • The Agency billed 252 units of Adult Habilitation from 09/01/2009 through 09/17/2009. Documentation received accounted for 212 units. • The Agency billed 332 units of Adult Habilitation		

	from 09/18/2009 through 09/30/2009. Documentation received accounted for 244 units.		

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6	Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 6 of 24 individuals receiving Community Living Services. • **Dental Exam** ° Individual #15 - As indicated by the documentation reviewed, exam was completed on 11/21/2008. Follow-up was to be completed in 6 months. No evidence of follow-up found. • **Auditory Exam** ° Individual #5 - As indicated by the documentation reviewed, exam was completed on 10/24/2008. Follow-up was to be completed in 1 year. No evidence of follow-up found. ° Individual #16 - As indicated by the documentation reviewed, exam was completed on 10/01/2008. Follow-up was to be completed in 1 year. No evidence of follow-up found. • **Bone Density Exam** ° Individual #4 - As indicated by the documentation reviewed, exam was completed on 07/10/2008. Follow-up was to be completed in 1 year. No evidence of follow-up found. ▪ **Cholesterol & Blood Glucose** ° Individual #13 - As indicated by the documentation reviewed, lab work was ordered on 06/23/2009. No evidence found to verify it was completed. ° Individual #16 – As indicated by the documentation reviewed, lab work was ordered on 03/20/2009. No evidence found to verify it was completed. • **Blood Levels**		

on the HAT, has a Health Care Plan developed by a licensed nurse. (c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition. (4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT. (5) That the physical property and grounds are free of hazards to the individual's health and safety. (6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following: (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).	° Individual #13 - As indicated by the documentation reviewed, lab work was ordered on 06/23/2009. No evidence found to verify it was completed. ° Individual #18 - As indicated by the documentation reviewed, lab work was ordered on 07/06/2009. No evidence found to verify it was completed.		

Tag # 6L14 Residential Case File	Scope and Severity Rating: F		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 16 of 19 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 (#3, 4, 5, 8, 10, 16, 17, 19 & 20) • Annual ISP (#19) • Teaching & Support Strategies (#3, 18 & 19) • ISP Signature Page (#3, 4, 10, 19, 20 & 23) • Addendum A (#4, 6, 10, 19, 20, 23 & 24) • Individual Specific Training (#3 & 19) • Positive Behavioral Plan (#15) • Positive Behavioral Crisis Plan (#1 & 15) • Speech Therapy Plan (#4) • Occupational Therapy Plan (#12, 15 & 19) • Physical Therapy Plan (#5, 15 & 18) • Health Assessment Tool (#10) • **Special Health Care Needs** ° Meal Time Plan (#15) ° Nutritional Plan (#18) • **Health Care Plans**		

a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital	° Blood Pressure (#3) ° Diabetes (#16) ° Hyperthyroid (#19) ° Hyperlipidema (#19) ° General Health (#24) ° Seizures (#24) ° Exercise (#24) ° Skin Breakdown (#24) • **Crisis Plan** ° Hypertension (#8) ° GERD (#15) ° Diabetes (#16) ° Seizures (#24) • **Progress Notes/Daily Contacts Logs:** ° Individual #4 - None found for January 1 - 3, 2010 ° Individual #19 - None found for January 1 - 4, 2010 • **Data Collection/Data Tracking:** ° Individual #4 - None found for January 1 - 3, 2010 ° Individual #19 - None found for January 1 - 4, 2010 • **Health Care Providers Written Orders** (#12 & 23)		

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

Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: D		
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 2 of 19 Supported Living & Family Living residences. The following items were not found, not functioning or incomplete: **Family Living Requirements:** • 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 (#4 & 9)		

Tag # 6L26 SL Reimbursement	Scope and Severity Rating: B		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES** A. **Reimbursement** for Supported Living Services (1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year. (2) **Billable Activities** (a) Direct care provided to an individual in the residence any portion of the day. (b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community. (c) Any activities in which direct support staff provides in accordance with the Scope of Services. (3) Non-Billable Activities (a) The Supported Living Services provider shall not bill DD Waiver for Room and Board. (b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services. (c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 1 of 2 individuals. Individual #17 September 2009 • The Agency billed 4 units of Supported Living from 09/01/2009 through 09/04/2009. Documentation received accounted for 3 units. • The Agency billed 17 units of Supported Living from 09/07/2009 through 09/23/2009. Documentation received accounted for 16 units.		

Tag # 6L27 FL Reimbursement	Scope and Severity Rating: A		
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. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **Chapter 6 - COMMUNITY LIVING SERVICES** **III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES** **C. Service Limitations**. Family Living Services	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 3 of 17 individuals. Individual #5 September 2009 • The Agency billed 30 units of Family Living from 09/01/2009 through 09/30/2009. Documentation received accounted for 29 units. Individual #6 October 2009 • The Agency billed 27 units of Family Living from 10/04/2009 through 10/30/2009. Documentation received accounted for 26 units. Individual #12 September 2009 • The Agency billed 24 units of Family Living from 09/01/2009 through 09/24/2009. Documentation received accounted for 18 units. October 2009 • The Agency billed 30 units of Family Living from 11/02/2009 through 11/31/2009. Documentation received accounted for 28 units. November 2009 • The Agency billed 20 units of Family Living from 11/01/2009 through 11/20/2009. Documentation received accounted for 19 units.		

cannot be provided in conjunction with any other Community Living Service, Personal Support Service, Private Duty Nursing, or Nutritional Counseling. In addition, Family Living may not be delivered during the same time as respite; therefore, a specified deduction to the daily rate for Family Living shall be made for each unit of respite received. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **DEFINITIONS** **SUBSTITUTE CARE** means the provision of family living services by an agency staff or subcontractor during a planned/scheduled or emergency absence of the direct service provider. **RESPITE** means a support service to allow the primary caregiver to take a break from care giving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.			

Date: March 9, 2010

To: Michael Binkley, President
Provider: Su Vida Services, Inc.
Address: 8501 Candelaria NE Building A
State/Zip: Albuquerque, New Mexico 87112

E-mail Address: mikebinkley@suvidaservices.com

Boardchair
E-Mail Address: patsyrios@suvidaservices.com

Region: Metro, Northeast & Northwest
Survey Date: January 4 – 11, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living, Independent Living & Family Living) & Community Inclusion (Adult Habilitation & Community Access)
Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Mr. Binkley,

Your request for a Reconsideration of Findings was received on February 25, 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 # 1A11

Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, and review of the training verification form, information was requested from your agency regarding transportation training and signed for by "MB," no date given, "M." on 1/7/10 and 1/8/10, and by V. Miracle on 1/7/10. As of the time of the exit meeting these documents had not been supplied. Also disputed in your request for IRF was staff #190; this staff was not originally cited in the QMB report of findings. The remaining citations noted in tag 1A11 were not disputed. The scope and severity rating will remain "D."

Regarding Tag # 1A12
Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, and review of applicable statutes and regulations and required by Dept. of Health Technical Assistance Document/Service Delivery Documentation (Nov. 2001), New Mexico Administrative Code (NMAC) 8.302.1.17.C; and MAD-MR: 03-59 (eff 1/1/04) 8.314.1 Record Keeping and Documentation Requirements, it is necessary to document "actual time" spent with recipients. These cited regulations are not specific to type of service provided and cover all services cited within tag 1A12 of the QMB report of findings. The scope and severity rating will remain "B."

Regarding Tag # 1A15 (Nurse Availability)
Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, and review of staff interviews, your agency was cited for staff competency issues rather than training (Staff # 89, 259, 109, 60). The remaining citations noted in tag 1A15 were not disputed. The scope and severity rating will remain "E."

Regarding Tag # 1A15 (Healthcare Documentation)
Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, and review of Individual ISPs, your agency was cited for items noted within the ISP of #15. Your dispute was the need for a nutrition assessment was "on the initial ISP in error." The IDT process allows for review and revisions of errors in the ISP prior to implementation of the ISP, which was not done. The remaining citations noted in tag 1A15 were not disputed. The scope and severity rating will remain "D."

Regarding Tag # 1A20
Determination: The IRF committee is modifying the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, and internal training field tools deficiencies originally cited for staff #189, 190 and 230 will be removed due to their not being employed by your agency; although to clarify a point, this information should have been and was not shared with the survey team during the on-site survey. Missing trainings for the following were requested of your agency via the training checklist and signed for by "MB," no date given, "M." on 1/7/10 and 1/8/10, and by V. Miracle on 1/7/10. As of the time of the exit meeting these documents had not been supplied.

- **Pre Service** (DSP #169)
- **Basic Health/Orientation** (DSP #108)
- **Person-Centered Planning** (DSP #216)
- **First Aid** (DSP #244)
- **Assisting With Medication Delivery** (DSP #41, 42, 62, 64, 127, 146, 177, 195, 199, 204, 211, 242, 244, 249, 258, 262, 277)
- **Participatory Communication and Choice Making** (DSP# 57, 84, 175)
- **Rights and Advocacy** (DSP# 95)
- **Teaching and Support Strategies** (DSP# 83, 174, 204, 266)

As for further disputes noted in your request for IRF, some inconsistencies were noted as follows:

- **Pre Service** (DSP #76, 79) – Not cited in the original report of findings under tag 1A20
- **Assisting With Medication Delivery** (DSP #110) – Not cited in the original report of findings under tag 1A20
- **Participatory Communication and Choice Making** (DSP# 233) – Not cited in the original report of findings under tag 1A20

- **Person-Centered Planning** (DSP #121) – Not cited in the original report of findings under tag 1A20
- **Level One Health** (DSP# 124) – Not cited in the original report of findings under tag 1A20

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

Regarding Tag # 1A25
Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, and document request forms, information requested regarding CCHSP clearance for staff #40, 176, 206, 237 and 250 by "MB," no date given, "M." on 1/7/10 and 1/8/10, and by V. Miracle on 1/7/10. As of the time of the exit meeting these documents had not been supplied. The remaining citations noted in this tag 1A25 were not disputed. The scope and severity rating will remain "D."

Regarding Tag # 1A26
Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, all deficiencies for staff will be upheld due to the date of the EAR/COR verification being done on or after the date of hire. According to NMAC 7.1.12.8.D "…records that evidence the fact that the provider made an inquiry to the registry concerning that employee prior to employment." The remaining citations noted in this tag 1A26 were not disputed. The scope and severity rating will remain "E."

Regarding Tag # 1A28
Determination: The IRF committee is modifying the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, and document request forms, information regarding abuse, neglect and exploitation training for staff #126, 138, 139, 142, 144, 160, 162, 165, 167, 168, 170, 180, 202, 217 will be removed. Based on the document request form, signed by "MB," no date given, "M." on 1/7/10 and 1/8/10, and by V. Miracle on 1/7/10; deficiencies for staff #78, 87, 98, 107, 189, 191, 192, 227, 245, 246, 280, 281, 283, 286, 287, 288, 293, 296 will be upheld. The citation for staff #156 will be upheld due to staff competency, rather than training. The remaining citations noted in this tag 1A28 were not disputed. The scope and severity rating will be changed to "D."

Regarding Tag # 1A37
Determination: The IRF committee is modifying the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, and the document request form, proof of Individual Specific Training (IST) was requested from your agency, signed by "MB," no date given, "M." on 1/7/10 and 1/8/10, and by V. Miracle on 1/7/10, the following was determined:

- **Remove** – DSP #69, incorrectly cited in QMB report of findings.
- **Remove** – Staff trained by previous agency (CLF) – DSP# 40, 41, 42, 45, 78, 110, 111, 112, 113, 114, 140, 173, 188, 189, 194, 222, 253, 254, 255, 256, 270, 271, 272, 273 and 297
- **Uphold** – 50, 52, 57, 58, 61, 63, 65, 67, 68, 72, 75, 79, 81, 88, 93, 98, 105, 120, 121, 138, 139, 141, 154, 166, 184, 186, 192, 193, 196, 198, 200, 212, 213, 214, 218, 219, 223, 225, 228, 233, 238, 249, 251, 264, 266, 267, 277, 279, 283, 288, 291, 306

The remaining citations noted in this tag 1A37 were not disputed. The scope and severity rating will remain "E."

Regarding Tag # 5I44
Determination: The IRF committee is removing the original finding in the report. Based on documentation supplied, all deficiencies will be removed.

Regarding Tag # 6L25

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

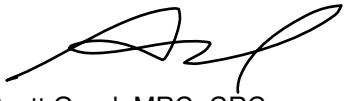
- Individual #4 – sign by Louis Garay on 1/5/10
- Individual #9 – sign by Donna Lane on 1/6/10

The remaining citations noted in tag 6L25 were not disputed. The scope and severity rating for this tag will remain "D."

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