



SUSANA MARTINEZ, GOVERNOR

CATHERINE D. TORRES, M.D., CABINET SECRETARY

Date: August 26, 2011

To: Joe Madrid, Executive Director  
Provider: Tobosa Developmental Services  
Address: 110 E. Summit  
State/Zip: Roswell, NM 88203

E-mail Address: [jmadrid@trytobosa.org](mailto:jmadrid@trytobosa.org)

CC: Doris Callaway, Board Chair  
Address: 3100 S. Main  
State/Zip: Roswell, NM 88203  
Board Chair  
E-Mail Address: [zzbill@plateautel.net](mailto:zzbill@plateautel.net)

Region: Southeast  
Survey Date: July 18 – 20, 2011  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Living Supports (Supported Living, & Independent Living) & Inclusion Supports (Adult Habilitation, Community Access & Supported Employment,)

Survey Type: Routine  
Team Leader: Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Crystal Lopez-Beck, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Maurice Gonzalez, BS, Health Ed., Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Paula Summers, BS, Planner, Developmental Disabilities Supports Division

Dear Mr. Madrid:

The Division of Health Improvement/Quality Management Bureau has completed a compliance 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. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider contracts. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

**Quality Management Determination of Compliance:**

The Division of Health Improvement is issuing your agency a determination of “Non-Compliance with Conditions of Participation.”



**DIVISION OF HEALTH IMPROVEMENT • QUALITY MANAGEMENT BUREAU**  
5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108  
(505) 222-8623 • FAX: (505) 222-8661 • <http://www.dhi.health.state.nm.us>

QMB Report of Findings – Tobosa Developmental Services - Southeast Region – July 18 – 20, 2011

Survey Report #: Q12.01.D1129.SE.001.RTN.01

**Plan of Correction:**

The attached Report of Findings identifies deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. See attachment "A" for additional guidance in completing the Plan of Correction. The response is due to the parties below within 10 business 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 business days. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as all remedies must still be completed within 45 business days of the receipt of this letter.

Failure to submit, complete or implement your Plan of Correction within the 45 day required time frames may 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 finding of deficient practice, you have 10 business 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

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 business days. Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

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

Sincerely,

*Deb Russell, BS*

Deb Russell, BS  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: July 18, 2011

Present: **Tobosa Developmental Services**  
Rosie Rubio, Assistant Director

**DOH/DHI/QMB**  
Deb Russell, BS, Team Lead/Healthcare Surveyor

**DDSD - Southeast Regional Office**  
Paula Summers, BS, Planner

Exit Conference Date: July 20, 2011

Present: **Tobosa Developmental Services**  
Rosie Rubio, Assistant Director  
Joe Madrid, Executive Director  
Michelle Lyon, Program Director  
Karolyn Anderson, Program Director  
Joan Blodgett, Executive Secretary

**DOH/DHI/QMB**  
Deb Russell, BS, Team Lead/Healthcare Surveyor  
Nadine Romero, LBSW, Healthcare Surveyor  
Crystal Lopez-Beck, BA, Healthcare Surveyor  
Maurice Gonzales, BS, Health Ed., Healthcare Surveyor

**DDSD - Southeast Regional Office**  
Paula Summers, BS, Planner

Total Homes Visited	Number:	9
❖ Supported Homes Visited	Number:	9
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	13 2 - <i>Jackson</i> Class Members 11 - Non- <i>Jackson</i> Class Members 11 - Supported Living 2- Independent Living 11 - Adult Habilitation 5 - Community Access 8 - Supported Employment
Persons Served Interviewed	Number:	7
Persons Served Observed	Number:	6 (4 Individuals did not respond to surveyor questions & 2 Individuals were not available during the on-site survey)
Person Served Records Reviewed	Number:	13
Direct Service Professionals Interviewed	Number:	21
Direct Service Professionals Record Review	Number:	120
Service Coordinator Record Review	Number:	4
Administrative Files Reviewed		

- Billing Records

- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Human Rights Notes and/or Meeting Minutes
- Evacuation Drills
- Quality Assurance / Improvement Plan
- Quality Assurance Committee Review of Medication Errors & Incident Reports

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

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

### **Introduction:**

After a QMB Compliance Review, your QMB Report of Findings will be sent to you via US mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued non compliance.

Agencies must submit their Plan of Correction within 10 business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 days will be referred to the Internal Review Committee [IRC] for sanctions).

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-222-8647 or email at [George.Perrault@state.nm.us](mailto:George.Perrault@state.nm.us). Requests for technical assistance must be requested through your DDS Regional Office.

If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) days of receiving your report. The POC process cannot resolve disputes regarding findings. Please note that you must still submit a POC for findings that are in question (see Attachment "C").

### **Instructions for Completing Agency POC:**

#### **Required Content**

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan. (see page 3, DDW standards, effective; April 1, 2007, Chapter 1, Section I Continuous Quality Management System)

If a deficiency has already been corrected, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

The Plan of Correction you submit needs to address **each deficiency** in the two right hand columns with:

1. How the corrective action will be accomplished for all cited deficiencies in the report of findings;
2. How your Agency will identify all other individuals having the potential to be affected by the same deficient practice;
3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur and corrective action is sustained;
4. How your Agency plans to monitor corrective actions utilizing its continuous Quality Assurance/Quality Improvement Plan to assure solutions in the plan of correction are achieved and sustained, including (if appropriate):
  - Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
  - Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
  - Your processes for ensuring that all staff are trained in Core Competencies, Incident Reporting, and Individual-Specific service requirements, etc;
  - How accuracy in Billing documentation is assured;
  - How health, safety is assured;

- For Case Management Providers, how ISPs are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
  - Your process for gathering, analyzing and responding to Quality data, and
  - Details about Quality Targets in various areas, current status, Root Cause Analyses about why Targets were not met, and remedies implemented.
5. The individual's title responsible for the Plan of Correction and completion date.

**Note: Instruction or in-service of staff alone may not be a sufficient plan of correction.** This is a good first step toward correction, but additional steps should be taken to ensure the deficiency is corrected and will not recur.

### **Completion Dates**

The plan of correction must include a **completion date** (entered in the far right-hand column). Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 days.

Direct care issues should be corrected immediately and monitored appropriately. Some deficiencies may require a staged plan to accomplish total correction. Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

### **Plan of Correction Submission Requirements**

1. Your Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. If you have questions about the POC process, call the POC Coordinator, George Perrault at 505-222-8647 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to George Perrault, POC Coordinator in any of the following ways:
  - a. Electronically at [George.Perrault@state.nm.us](mailto:George.Perrault@state.nm.us)
  - b. Faxed to 505-222-8661, or
  - c. Mailed to QMB, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not send supporting documentation to QMB until after your POC has been approved by QMB.
6. QMB will notify you when your POC has been "approve" or "denied."
  - a. Whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
  - b. If your POC is "Denied" it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
  - c. If your POC is "Denied" a second time your agency may be referred to the Internal Review Committee.
  - d. You will receive written confirmation that your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.
8. Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

### ***POC Document Submission Requirements***

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.
2. You may submit your documents by postal mail, fax, or electronically on disc or scanned and attached to e-mails.
3. All submitted documents must be annotated: please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. For billing deficiencies, you must submit:
  - a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
  - b. Copies of "void and adjust" forms submitted to correct all over-billed or unjustified units billed identified during your internal audit.

## QMB Scope and Severity Matrix

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

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

### Scope and Severity Definitions:

- **Isolated:**  
A deficiency that is limited to 1% to 15% of the sample, usually impacting few individuals in the sample.
  
- **Pattern:**  
A deficiency that impacts a number or group of individuals from 16% to 79% of the sample is defined as a pattern finding. Pattern findings suggest the need for system wide corrective actions.
  
- **Widespread:**  
A deficiency that impacts most or all (80% to 100%) of the individuals in the sample is defined as widespread or pervasive. Widespread findings suggest the need for system wide corrective actions as well as the need to implement a Continuous Quality Improvement process to improve or build infrastructure. Widespread findings could be referred to the Internal Review Committee for review and possible actions or sanctions.



## QMB Determinations of Compliance

- “Substantial Compliance with Conditions of Participation”

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

- “Non-Compliance with Conditions of Participation”

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

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

- “Sub-Standard Compliance with Conditions of Participation”:

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

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

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

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

### **Introduction:**

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

### **Instructions:**

1. The Informal Reconsideration of the Finding (IRF) request must be in writing to the QMB Deputy Bureau Chief **within 10 working days** of receipt of the final report.
2. The written request for an IRF must be completed on the QMB Request for Informal Reconsideration of Finding Form available on the QMB website: <http://dhi.health.state.nm.us/qmb>
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.

### **The following limitations apply to the IRF process:**

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

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

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

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

**Agency:** Tobosa Developmental Services - Southeast Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Living Supports (Supported Living & Independent Living) & Inclusion Supports (Adult Habilitation, Community Access & Supported Employment,)  
**Monitoring Type:** Routine Survey  
**Date of Survey:** July 18 – 20, 2011

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<b>Tag # 1A09 Medication Delivery (MAR) - Routine Medication</b>	<b>Scope and Severity Rating: D</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>E. Medication Delivery:</b> Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <p>(a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and generic name of the medication,</p>	<p>Medication Administration Records (MAR) were reviewed for the months of April, May &amp; June 2011.</p> <p>Based on record review, 2 of 13 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #9 June 2011 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Temovate Cream 0.5% (2 times daily)</li> </ul> <p>Individual #10 May 2011 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Ensure (2 times daily)</li> </ul> <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> <li>• Ensure (2 times daily)</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p>	

<p>diagnosis for which the medication is prescribed;</p> <p>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</p> <p>(c) Initials of the individual administering or assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p><b>NMAC 16.19.11.8 MINIMUM STANDARDS:</b>  <b>A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</b></p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, <b>including over-the-counter medications</b>. This documentation shall include:</p> <p>(i) Name of resident;</p>			
--	--	--	--

- (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.

**Model Custodial Procedure Manual**

***D. Administration of Drugs***

Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

Tag # 1A09.2 Medication Delivery - PRN Nurse Approval	Scope and Severity Rating: F	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>E. Medication Delivery:</b> Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDS Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p><b>Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006</b></p> <p><b>F. PRN Medication</b></p> <p>3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to</p>	<p>Based on record review and interview, the Agency failed to maintain documentation of PRN usage as required by standard for 1 of 13 Individuals.</p> <p>Individual #9 June 2011 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Diphenhydramine 25mg – PRN – 6/13 (given 1 time)</li> </ul> <p>July 2011 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Maalox – PRN – 7/1 (given 1 time)</li> </ul> <p>When #164, was asked if the Agency had nursing documentation indicating Nursing Personnel were called prior to administering/assisting individuals with PRN Medications, the following was reported:</p> <ul style="list-style-type: none"> <li>• #164 stated, “The house managers have been received training from the RN to do that.”</li> </ul> <p>When Surveyors asked for further clarification, Surveyors were presented with the Agency’s “Protocol for ‘As Needed’ or PRN Medications” which stated,</p> <p><i>“House managers will be delegated by the nurse to give permission for PRN medications under the following guidelines:</i></p> <p><i>“Between 6 pm and 7 am only; Monday thru Friday and all hours over the weekend. All other medication requests during office hours must be requested from the nursing</i></p>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

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

*office. This allows nursing to evaluate or schedule appt if needed.*

*Ibuprofen 200mg: Administer two tablets via route indicated on the MAR (X 1 time)  
Fever greater than 100°F  
Complaint of pain unrelieved by rest*

*Tylenol 500mg Administer two tablets via route indicated on MAR (X1 time)  
Fever greater than 100°F  
Complaint of pain unrelieved by rest*

*Maalox Susp Administer one to two tablespoonfuls (15-30 ml) via route on MAR every 1 to 3 hours (X 2 times)  
Upset stomach  
Indigestion  
Heartburn  
Nausea  
Diarrhea*

*Mylanta Susp Administer two to four tablespoonfuls (15-30 ml) via route on MAR every 1 to 3 hours (X 2 times)  
Gas  
Indigestion*

*Benedryl 25 mg capsule Administer one to two capsules via route on MAR every 4 to 6 hours (X2 times)  
Runny nose  
Sneezing  
Itchy and/or watery eyes*

*Robitussin DM (generic Tussin DM) Administer one to two teaspoons (5-10 cc) via route on MAR every 4-6 hours (X 2 doses)  
Cough due to minor sore throat or congestion*

*Hydrocortisone Cream 1% Apply a thin layer to affected areas every 4-6 hours (X3 doses a day for 3 days)  
Skin rash or irritation*

*Triple Antibiotic Ointment Apply to affected area (X4 times a day for 3 days)  
Cuts and scrapes*

*Once you have approved the PRN for the maximum*

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.

*amount of times listed above; the house manager must notify the supervisor, who will notify nursing, for advice or approval to administer any more doses. Notify supervisor if at any time a medication approved was not effective for treatment. Supervisor will notify nurse at this time.*

As the Agency's protocol was contradictory with the DDSD policy on Medication Assessment & Delivery Assistant Director (#164) was asked if they had for a written exception from DDSD indicating that direct support staff did not need to contact the agency nurse prior to delivery of PRN medications as directed by their protocol, the Assistant Director (#164) stated, "We thought we had it."

DDSD Southwest Regional Director was notified of this issue during the on-site survey.



Tag # 1A11.1 (CoP) Transportation Training	Scope and Severity Rating: D	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards...</p> <p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff Date:</b> March 1, 2007</p> <p><b>II. POLICY STATEMENTS:</b></p> <p>1. 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:</p> <ol style="list-style-type: none"> <li>1. Operating a fire extinguisher</li> <li>2. Proper lifting procedures</li> <li>3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat)</li> <li>4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)</li> <li>5. Operating wheelchair lifts (if applicable to the staff's role)</li> <li>6. Wheelchair tie-down procedures (if applicable to the staff's role)</li> <li>7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)</li> </ol>	<p>Based on record review, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 1 of 120 Direct Service Professionals.</p> <p>No documented evidence was found of the following required training:</p> <ul style="list-style-type: none"> <li>• Transportation (DSP #90)</li> </ul>	<p>Provider: Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: D	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> 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.</p> <p><b>C. Orientation and Training Requirements:</b> Orientation and training for direct support staff and his or her supervisors shall comply with the DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <ol style="list-style-type: none"> <li>(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</li> <li>(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.</li> </ol> <p><b>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:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 9 of 120 Direct Service Professionals.</p> <p>Review of Direct Service Professionals training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> <li>• Foundation for Health &amp; Wellness (DSP #90 &amp; 127)</li> <li>• First Aid (DSP #52, 71 &amp; 123)</li> <li>• CPR (DSP #40, 42, 46, 71 &amp; 104)</li> <li>• Teaching &amp; Support Strategies (DSP #40)</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p>

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.

Tag # 1A22 Staff Competence	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> 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.</p> <p><b>F. Qualifications for Direct Service Personnel:</b> The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</p> <ol style="list-style-type: none"> <li>(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;</li> <li>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</li> <li>(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;</li> <li>(4) Direct service personnel shall meet the qualifications specified by DDS in the Policy</li> </ol>	<p>Based on interview, the Agency failed to ensure that training competencies were met for 4 of 21 Direct Service Professionals.</p> <p><b>When DSP were asked if they received training on the Individual’s Physical Therapy Plan and what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #145 stated, “We have tried to set up trainings with the therapist but he is hard to get a hold of.” According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan. (Individual #6)</li> </ul> <p><b>When DSP were asked, what are the steps did they need to take before assisting an individual with PRN medication, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #82 stated, “Call my house manager and she tells me yes or no and how much.” According to DDS 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 #5 &amp; 9)</li> <li>• DSP #94 stated, “Call house manager or day hab supervisor.” According to DDS 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)</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

<p>Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and</p> <p>(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.</p> <p>(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:</p> <p>(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;</p> <p>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</p> <p>(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p> <p><b>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:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.</p>	<p>(Individual #7)</p> <ul style="list-style-type: none"> <li>• DSP #131 stated, "First call my supervisor." 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)</li> </ul>		
---	---	--	--

Tag # 1A27(CoP) IMB Late & Failure to Report	Scope and Severity Rating: E	
<p><b>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</b></p> <p><b>A. Duty To Report:</b></p> <p>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</p> <p>(2) All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:</p> <p>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</p> <p>(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.</p> <p>(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.</p> <p><b>B. Notification: (1) Incident Reporting:</b> Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, <a href="http://dhi.health.state.nm.us/elibrary/ironline/ir.php">http://dhi.health.state.nm.us/elibrary/ironline/ir.php</a> or may be obtained from the department by calling the toll free number.</p>	<p>Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 13 of 23 individuals.</p> <p>Individual #3</p> <ul style="list-style-type: none"> <li>• Incident date 4/16/2011. Allegation was Neglect. Incident report was received 4/20/2011. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was "Confirmed."</li> <li>• Incident date 5/23/2011. Allegation was Neglect. Incident report was received 6/8/2011. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was "Confirmed."</li> </ul> <p>Individual #6</p> <ul style="list-style-type: none"> <li>• Incident date 2/2/2011. Allegation was Neglect. Incident report was received 3/9/2011. Failure to Report. IMB Late &amp; Failure Report indicated incident of Neglect was "Confirmed."</li> </ul> <p>Individual #8</p> <ul style="list-style-type: none"> <li>• Incident date 7/13/2010. Allegation was Neglect. Incident report was received 7/22/2010. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was "Confirmed."</li> <li>• Incident date 12/2/2010. Allegation was Neglect. Incident report was received 1/6/2011. Failure to Report. IMB Late &amp; Failure Report indicated incident of Neglect was "Confirmed."</li> </ul> <p>Individual #14</p> <ul style="list-style-type: none"> <li>• Incident date 8/5/2010. Allegation was Neglect. Incident report was received 8/11/2010. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was "Confirmed."</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p>

	<p>Individual #15</p> <ul style="list-style-type: none"> <li>• Incident date 8/5/2010. Allegation was Neglect. Incident report was received 8/11/2010. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</li> </ul> <p>Individual #16</p> <ul style="list-style-type: none"> <li>• Incident date 9/21/2010. Allegation was Exploitation. Incident report was received 9/24/2010. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</li> </ul> <p>Individual #17</p> <ul style="list-style-type: none"> <li>• Incident date 11/18/2010. Allegation was Neglect. Incident report was received 11/30/2010. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</li> <li>• Incident date 5/5/2011. Allegation was Abuse. Incident report was received 5/9/2011. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</li> </ul> <p>Individual #18</p> <ul style="list-style-type: none"> <li>• Incident date 12/3/2010. Allegation was Neglect. Incident report was received 12/9/2010. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</li> <li>• Incident date 12/13/2010. Allegation was Exploitation. Incident report was received 1/25/2011. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</li> </ul> <p>Individual #19</p> <ul style="list-style-type: none"> <li>• Incident date 2/2/2011. Allegation was Neglect. Incident report was received 2/10/2011. Failure to Report. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</li> </ul>		
--	---	--	--

	<p>Individual #20</p> <ul style="list-style-type: none"> <li>• Incident date 4/16/2011. Allegation was Neglect. Incident report was received 4/20/2011. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</li> </ul> <p>Individual #21</p> <ul style="list-style-type: none"> <li>• Incident date 4/27/2011. Allegation was Neglect. Incident report was received 5/9/2011. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</li> </ul> <p>Individual #22</p> <ul style="list-style-type: none"> <li>• Incident date 5/10/2011. Allegation was Neglect. Incident report was received 5/13/2011. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</li> </ul> <p>Individual #23</p> <ul style="list-style-type: none"> <li>• Incident date 2/1/2011. Allegation was Neglect. Incident report was received 5/20/2011. Failure to Report. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</li> </ul>		
--	--	--	--



<b>Tag # 1A28.1 (CoP) Incident Mgt. System - Personnel Training</b>	<b>Scope &amp; Severity Rating: D</b>	
<p><b>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b></p> <p><b>A. General:</b> 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.</p> <p><b>D. Training Documentation:</b> 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.</p> <p><b>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</b></p> <p><b>II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p>	<p>Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 4 of 124 Agency Personnel.</p> <ul style="list-style-type: none"> <li>• Incident Management Training (Abuse, Neglect &amp; Misappropriation of Consumers' Property) (#160)</li> </ul> <p><b>When Direct Service Professionals were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect &amp; Misappropriation of Consumers' Property, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #43 stated, "DOH, I can't remember the other one."</li> <li>• DSP #102 stated, "If there are any problems I talk to the Incident Management Coordinator and he does the incidents."</li> <li>• DSP #136 stated, "DHI." DSP did not state APS.</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

Tag # 1A32 & 6L14 (CoP) ISP Implementation	Scope and Severity Rating: D	
<p><b>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP.</b> The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<p>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 13 individuals.</p> <p>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p><b>Administrative Files Reviewed:</b></p> <p><b>Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #3  <ul style="list-style-type: none"> <li>◦ None found for 6/2011</li> </ul> </p>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

Tag # 1A33 Board of Pharmacy - Medication Storage	Scope and Severity Rating: A	
<p><b>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual</b></p> <p><b>E. Medication Storage:</b></p> <ol style="list-style-type: none"> <li>1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee.</li> <li>2. Drugs to be taken by mouth will be separate from all other dosage forms.</li> <li>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.</li> <li>4. Separate compartments are required for each resident's medication.</li> <li>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.</li> <li>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.</li> </ol> <p><b>8. References</b></p> <p>A. Adequate drug references shall be available for facility staff</p> <p><b>H. Controlled Substances (Perpetual Count Requirement)</b></p> <ol style="list-style-type: none"> <li>1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance, indicating the following information: <ol style="list-style-type: none"> <li>a. date</li> <li>b. time administered</li> <li>c. name of patient</li> </ol> </li> </ol>	<p>Based on observation, the Agency failed to ensure proper storage of medication for 2 of 13 individuals.</p> <p>Observation included:</p> <p>Individual #1 Clobetasol 0.05% expired 5/26/2010. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.</p> <p>Individual #4 Tramadol 5mg expired 8/3/2010. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.</p>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

d. dose  
e. practitioner's name  
f. signature of person administering or assisting with the administration the dose  
g. balance of controlled substance remaining.

Tag # 5I25 SE Reimbursement	Scope and Severity Rating: B	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>A. General:</b> 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.</p> <p><b>B. Billable Units:</b> 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:</p> <ol style="list-style-type: none"> <li>(1) Date, start and end time of each service encounter or other billable service interval;</li> <li>(2) A description of what occurred during the encounter or service interval; and</li> <li>(3) The signature or authenticated name of staff providing the service.</li> </ol> <p><b>MAD-MR: 03-59 Eff 1/1/2004</b></p> <p><b>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b></p> <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</b></p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 5 of 8 individuals</p> <p>Individual #5 April 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 3 units of Adult Habilitation from 4/1/2011 through 4/30/2011. Documentation received accounted for 0 units.</li> </ul> <p>Individual #9 April 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 4/1/2011 through 4/30/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 4/5 &amp; 7 to justify billing. Additionally, review of documentation indicated services were provided concurrently with Adult Habilitation on 4/12, 14, 21 &amp; 28.</li> </ul> <p>May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 5/1/2011 through 5/31/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 5/5, 10 &amp; 12 to justify billing. Additionally, review of documentation indicated services were provided concurrently with Adult Habilitation on 5/3, 5, 10, 12, 17 &amp; 24</li> </ul> <p>June 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 6/1/2011 through 6/30/2011. Documentation did not contain a signature/authenticated name of the staff providing the service 6/2, 3, 9, 14, 16, 21, 23 &amp; 30 to justify billing. Additionally, review of documentation indicated services were provided concurrently with Adult Habilitation on 6/2, 12 &amp;</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

<p><b>E. Reimbursement</b></p> <p>(1) Billable Unit:</p> <p>(a) Job Development is a single flat fee unit per ISP year payable once an individual is placed in a job.</p> <p>(b) The <b>billable unit for Individual Supported Employment</b> is one hour with a maximum of four hours a month. The Individual Supported Employment hourly rate is for face-to-face time which is supported by non face-to-face activities as specified in the ISP and the performance based contract as negotiated annually with the provider agency. Individual Supported Employment is a minimum of one unit per month. If an individual needs less than one hour of face-to-face service per month the IDT Members shall consider whether Supported Employment Services need to be continued. Examples of non face-to-face services include:</p> <ul style="list-style-type: none"> <li>(i) Researching potential employers via telephone, Internet, or visits;</li> <li>(ii) Writing, printing, mailing, copying, emailing applications, resume, references and corresponding documents;</li> <li>(iii) Arranging appointments for job tours, interviews, and job trials;</li> <li>(iv) Documenting job search and acquisition progress;</li> <li>(v) Contacting employer, supervisor, co-workers and other IDT team members to assess individual's progress, needs and satisfaction; and</li> <li>(vi) Meetings with individual surrounding job development or retention not at the employer's site.</li> </ul> <p>(c) Intensive Supported Employment services are intended for individuals who need one-to-one, face-to-face support for 32 or more hours per month. The billable unit is one hour.</p> <p>(d) Group Supported Employment is a fifteen-</p>	<p>16.</p> <p>Individual #10 May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 5/1/2011 through 5/31/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 5/31 to justify billing.</li> </ul> <p>June 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 6/1/2011 through 6/30/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 6/22, 23, 28 &amp; 30 to justify billing.</li> </ul> <p>Individual #11 April 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 4/1/2011 through 4/30/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 4/4, 5, 6, 13, 19, 20, 26 &amp; 27 to justify billing.</li> </ul> <p>May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 5/1/2011 through 5/31/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 5/2, 3, 4, 9, 11, 16, 17, 18, 23 &amp; 24 to justify billing.</li> </ul> <p>June 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 6/1/2011 through 6/30/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 6/8, 13, 15, 20 &amp; 22 to justify billing.</li> </ul>		
--	---	--	--

<p>minute unit.</p> <p>(e) Self-employment is a fifteen minute unit.</p> <p>(4) Billable Activities include:</p> <p>(a) Activities conducted within the scope of services;</p> <p>(b) Job development and related activities for up to ninety (90) calendar days) that result in employment of the individual for at least thirty (30) calendar days; and</p> <p>(c) Job development services shall not exceed ninety (90) calendar days, without written approval from the DDSD Regional Office.</p>	<p>Individual #12</p> <p>April 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 4/1/2011 through 4/30/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 4/4, 5, 6, 11, 12, 13, 18, 19, 20, 25 &amp; 26 to justify billing.</li> </ul> <p>May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 5/1/2011 through 5/31/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 5/2, 3, 4, 9, 10, 11, 16, 17, 18, 23, 24, 25 &amp; 31 to justify billing.</li> </ul> <p>June 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 6/1/2011 through 6/30/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 6/1, 6, 7, 8, 13, 14, 15, 20, 21, 27, 28 &amp; 29 to justify billing.</li> </ul>		
---	---	--	--

Tag # 5I36 CA Reimbursement	Scope and Severity Rating: B	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>A. General:</b> 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.</p> <p><b>B. Billable Units:</b> 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:</p> <ol style="list-style-type: none"> <li>(1) Date, start and end time of each service encounter or other billable service interval;</li> <li>(2) A description of what occurred during the encounter or service interval; and</li> <li>(3) The signature or authenticated name of staff providing the service.</li> </ol> <p><b>MAD-MR: 03-59 Eff 1/1/2004</b></p> <p><b>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b></p> <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS</b></p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 4 of 5 individuals.</p> <p>Individual #3 May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 139 units of Adult Habilitation from 5/1/2011 through 5/19/2011. Documentation received accounted for 124 units.</li> </ul> <p>Individual #8 May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 52 units of Community Access from 5/1/2011 through 5/31/2011. Documentation received accounted for 32 units.</li> </ul> <p>Individual #12 June 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 41 units of Community Access from 6/1/2011 through 6/26/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 6/3/2011 to justify billing.</li> </ul> <p>Individual #13 May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Community Access from 5/1/2011 through 5/28/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 5/5, 10, 12, 13, 16, 19, 26 &amp; 27 to justify billing.</li> </ul> <p>June 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 113 units of Community Access from 6/1/2011 through 6/30/2011. Documentation received accounted for 96 units. Additionally, documentation did not contain a</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>



**G. Reimbursement**

(1) **Billable Unit:** A billable unit is defined as one-quarter hour of service.

(2) **Billable Activities:** The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions:

- (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan;
- (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and
- (c) Non face-to-face hours do not exceed 10% of the monthly billable hours.

(3) **Non-Billable Activities:** Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include:

- (a) Time and expense for training service personnel;
- (b) Supervision of agency staff;
- (c) Service documentation and billing activities; or
- (d) Time the individual spends in segregated facility-based settings activities.

signature/authenticated name of the staff providing the service on 6/2, 9, 16, 23 & 30 to justify billing.

Tag # 5144 AH Reimbursement	Scope and Severity Rating: B	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>A. General:</b> 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.</p> <p><b>B. Billable Units:</b> 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:</p> <ol style="list-style-type: none"> <li>(1) Date, start and end time of each service encounter or other billable service interval;</li> <li>(2) A description of what occurred during the encounter or service interval; and</li> <li>(3) The signature or authenticated name of staff providing the service.</li> </ol> <p><b>MAD-MR: 03-59 Eff 1/1/2004</b></p> <p><b>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b></p> <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 XVI. REIMBURSEMENT</b></p> <p><b>A. Billable Unit.</b> A billable unit for Adult Habilitation</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 9 of 11 individuals.</p> <p>Individual #1 April 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 490 units of Adult Habilitation from 4/1/2011 through 4/30/201. Documentation received accounted for 457 units. Additionally, documentation did not contain a signature/authenticated name of the staff providing the service on 4/1, 2, 3, 5, 6, 7, 8, 9, 11, 12, 13, 15, 18, 19, 22, 25, 26, 27, 28 &amp; 29 to justify billing.</li> </ul> <p>May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 504 units of Adult Habilitation from 5/1/2011 through 5/31/201. Documentation received accounted for 448 units. Additionally, documentation did not contain a signature/authenticated name of the staff providing the service on 5/1, 2, 3, 4, 5, 6, 9, 11, 12, 17, 18, 19, 20, 23, 24, 25, 26, 27 &amp; 31 to justify billing.</li> </ul> <p>June 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 408 units of Adult Habilitation from 6/1/2011 through 6/30/201. Documentation received accounted for 383 units. Additionally, documentation did not contain a signature/authenticated name of the staff providing the service on 6/1, 2, 3, 9, 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 29 &amp; 30 to justify billing.</li> </ul> <p>Individual #2 April 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 476 units of Adult Habilitation from 4/1/2011 through 4/30/2011. Documentation received accounted for 388</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

<p>Services is in 15-minute increments hour. The rate is based on the individual's level of care.</p> <p><b>B. Billable Activities</b></p> <p>(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.</p> <p>(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</p>	<p>units.</p> <p>May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 459 units of Adult Habilitation from 5/1/2011 through 5/31/2011. Documentation received accounted for 436 units.</li> </ul> <p>June 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 373 units of Adult Habilitation from 6/1/2011 through 6/30/2011. Documentation received accounted for 282 units.</li> </ul> <p>Individual #3</p> <p>April 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 350 units of Adult Habilitation from 4/1/2011 through 4/30/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 4/6, 7, 12, 13, 14, 18, 19, 20, 21, 22, 25 &amp; 26 to justify billing.</li> </ul> <p>May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 255 units of Adult Habilitation from 5/1/2011 through 5/31/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 5/3, 4, 5, 10, 11, 12, 17, 19, 20, 24, 25 &amp; 27 to justify billing.</li> </ul> <p>June 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 331 units of Adult Habilitation from 6/1/2011 through 6/30/2011. Documentation did not contain a signature/authenticated name of the staff providing the service 6/9 &amp; 13 to justify billing.</li> </ul> <p>Individual #5</p> <p>May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 452 units of Adult Habilitation from 5/1/2011 through 5/31/2011.</li> </ul>	
---	---	--

	<p>Documentation received accounted for 419 units.</p> <p>Individual #6 April 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 504 units of Adult Habilitation from 4/1/2011 through 4/30/2011. Documentation received accounted for 452 units.</li> </ul> <p>Individual #8 June 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 408 units of Adult Habilitation from 6/1/2011 through 6/30/2011. Documentation received accounted for 296 units.</li> </ul> <p>Individual #9 April 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 433 units of Adult Habilitation from 4/1/2011 through 4/30/2011. The following was found: <ul style="list-style-type: none"> <li>◦ Documentation did not contain a signature/authenticated name of the staff providing the service on 4/4, 5, 6, 11, 13, 15, 18, 19, 20, 21, 22, 25 &amp; 29 to justify billing.</li> <li>◦ Review of documentation indicated services were provided concurrently with Supported Employment on 4/12, 14, 21 &amp; 28.</li> </ul> </li> </ul> <p>May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 434 units of Adult Habilitation from 5/1/2011 through 5/31/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 5/2, 3, 4, 5, 6, 9, 10, 11, 13 &amp; 17 to justify billing. Additionally, review of documentation indicated services were provided concurrently with Supported Employment on 5/3, 5/5, 5/10, 5/12, 5/17 &amp;</li> </ul>		
--	---	--	--

	<p>5/24.</p> <p>June 2011</p> <ul style="list-style-type: none"> <li>The Agency billed 4 units of Adult Habilitation from 6/1/2011 through 6/30/2011. The Documentation did not contain a signature/authenticated name of the staff providing the service 6/9 to justify billing. Additionally, review of documentation indicated services were provided concurrently with Supported Employment on 6/2, 16 &amp; 12.</li> </ul> <p>Individual #10</p> <p>April 2011</p> <ul style="list-style-type: none"> <li>The Agency billed 437 units of Adult Habilitation from 4/1/2011 through 4/30/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 4/1, 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28 &amp; 29 to justify billing. Additionally, review of documentation indicated services were provided concurrently with Supported Employment on 4/5 &amp; 4/7.</li> </ul> <p>May 2011</p> <ul style="list-style-type: none"> <li>The Agency billed 480 units of Adult Habilitation from 5/1/2011 through 5/31/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 5/2, 3, 4, 5, 6, 9, 10, 11, 13, 17, 18, 19, 20 &amp; 30 to justify billing. Additionally, review of documentation indicated services were provided concurrently with Supported Employment on 5/5.</li> </ul> <p>June 2011</p> <ul style="list-style-type: none"> <li>The Agency billed 391 units of Adult Habilitation from 6/1/2011 through 6/30/2011. Documentation received accounted for 376 units. Additionally, documentation did not contain a signature/authenticated name of the</li> </ul>		
--	---	--	--

	<p>staff providing the service on 6/1, 2, 3, 13, 14, 15, 16, 17, 21, 22, 23, 24, 27, 28 &amp; 30 to justify billing.</p> <p>Individual #11 April 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 437 units of Adult Habilitation from 4/1/2011 through 4/30/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 4/1, 4, 5, 7, 8, 11, 12, 13, 18, 19, 20, 21, 22, 25, 26, 27, 28 &amp; 29 to justify billing. Additionally, documentation indicated services were provided concurrently with Supported Employment on 4/20, 26 &amp; 28.</li> </ul> <p>May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 470 units of Adult Habilitation from 5/1/2011 through 5/31/2011. Documentation received accounted for 448 units.</li> </ul> <p>June 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 454 units of Adult Habilitation from 6/1/2011 through 6/30/2011. Documentation received accounted for 386 units. Additionally the following was found: <ul style="list-style-type: none"> <li>◦ Review of documentation indicated services were provided concurrently with Supported Employment on 6/28.</li> <li>◦ Documentation did not contain a signature/authenticated name of the staff providing the service on 6/13, 14, 15, 16, 20, 21, 22, 23, 24, 27, 28 &amp; 30 to justify billing.</li> </ul> </li> </ul>		
--	---	--	--

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: D	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</b></p> <p><b>G. Health Care Requirements for Community Living Services.</b></p> <p>(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.</p> <p>(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.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <p>(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.</p> <p>b) That each individual with a score of 4, 5, or 6</p>	<p>Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 2 of 13 individuals receiving Community Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• <b>Dental Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #1 - As indicated by collateral documentation reviewed, exam was completed on 11/9/09. Follow-up was to be completed in 12 months. No evidence of follow-up found.</li> <li>◦ Individual #13 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</li> </ul> </li> <li>• <b>Auditory Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #1 - As indicated by collateral documentation reviewed, exam was completed on 2/18/2010. Follow-up was to be completed in 12 months. No evidence of follow-up found.</li> </ul> </li> <li>• <b>Colonoscopy</b> <ul style="list-style-type: none"> <li>◦ Individual #13 - As indicated by collateral documentation reviewed, the PCP referral was made on 4/20/1011. No evidence of exam results were found.</li> </ul> </li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

<p>on the HAT, has a Health Care Plan developed by a licensed nurse.</p> <p>(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.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <p>(a) The individual has a primary licensed physician;</p> <p>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</p> <p>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</p> <p>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</p> <p>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</p> <p><b>NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b> A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.</p> <p><b>B. Documentation of test results:</b> Results of tests</p>			
---	--	--	--



and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

Tag # 6L14 Residential Case File	Scope and Severity Rating: F	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>A. Residence Case File:</b> 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:</p> <p>(1) Complete and current ISP and all supplemental plans specific to the individual;</p> <p>(2) Complete and current Health Assessment Tool;</p> <p>(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;</p> <p>(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);</p> <p>(5) Data collected to document ISP Action Plan implementation</p> <p>(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;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 11 of 11 Individuals receiving Supported Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• <b>Current Emergency &amp; Personal Identification Information</b> <ul style="list-style-type: none"> <li>◦ Did not contain Individual's current address Information (#1)</li> </ul> </li> <li>• Positive Behavioral Plan (#4)</li> <li>• Positive Behavioral Crisis Plan (#4)</li> <li>• Speech Therapy Plan (#1 &amp; 8)</li> <li>• Health Assessment Tool (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10 &amp; 11)</li> <li>• <b>Special Health Care Needs</b> <ul style="list-style-type: none"> <li>◦ Nutritional Plan (#1, 4, 7 &amp; 8)</li> <li>◦ CARMP(Comprehensive Aspiration Risk Management Plan (#8 &amp;10)</li> </ul> </li> <li>• <b>Data Collection/Data Tracking:</b> <ul style="list-style-type: none"> <li>◦ Individual #1 - None found 7/1 - 19, 2011</li> </ul> </li> <li>• <b>Record of visits of healthcare practitioners (#11)</b></li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

<p>a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> <li>(a) The name of the individual;</li> <li>(b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;</li> <li>(c) Diagnosis for which the medication is prescribed;</li> <li>(d) Dosage, frequency and method/route of delivery;</li> <li>(e) Times and dates of delivery;</li> <li>(f) Initials of person administering or assisting with medication; and</li> <li>(g) An explanation of any medication irregularity, allergic reaction or adverse effect.</li> <li>(h) For PRN medication an explanation for the use of the PRN must include: <ul style="list-style-type: none"> <li>(i) Observable signs/symptoms or circumstances in which the medication is to be used, and</li> <li>(ii) Documentation of the effectiveness/result of the PRN delivered.</li> </ul> </li> <li>(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.</li> </ul> <p>(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</p> <p>(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</p>			
--	--	--	--

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: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>L. Residence Requirements for Family Living Services and Supported Living Services</b></p> <p>(1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has:</p> <p>(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;</p> <p>(b) General-purpose first aid kit;</p> <p>(c) When applicable due to an individual's health status, a blood borne pathogens kit;</p> <p>(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;</p> <p>(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;</p> <p>(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;</p> <p>(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</p> <p>(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.</p>	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 2 of 9 Supported Living residences.</p> <p>Individuals #5 &amp; 9 and 10 &amp; 11 live in the same residences.</p> <p>The following items were not found, not functioning or incomplete:</p> <p><b>Supported Living Requirements:</b></p> <ul style="list-style-type: none"> <li>• Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#1)</li> <li>• Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#2)</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

Tag # 6L26 SL Reimbursement	Scope and Severity Rating: B	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>A. General:</b> 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.</p> <p><b>B. Billable Units:</b> 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:</p> <ol style="list-style-type: none"> <li>(1) Date, start and end time of each service encounter or other billable service interval;</li> <li>(2) A description of what occurred during the encounter or service interval; and</li> <li>(3) The signature or authenticated name of staff providing the service.</li> </ol> <p><b>MAD-MR: 03-59 Eff 1/1/2004</b></p> <p><b>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b></p> <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES</b></p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 4 of 11 individuals.</p> <p>Individual #5 April 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 30 units of Supported Living from 4/1/2011 through 4/30/201. Documentation did not contain a signature/authenticated name of the staff providing the service on 4/1, 2, 15, 16, 17, 23, 24, 29 &amp; 30 to justify billing.</li> </ul> <p>May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 31 units of Supported Living from 5/1/2011 through 5/31/201. Documentation did not contain a signature/authenticated name of the staff providing the service on 5/6, 13, 14, 15, 21, 22, 27, 28 &amp; 29 to justify billing.</li> </ul> <p>June 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 30 units of Supported Living from 6/1/2011 through 6/30/201. Documentation did not contain a signature/authenticated name of the staff providing the service on 6/11, 12, 18, 19, 24, 25 &amp; 26 to justify billing.</li> </ul> <p>Individual #6 April 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 29 units of Supported Living from 4/1/2011 through 4/30/201. Documentation did not contain a signature/authenticated name of the staff providing the service on 4/25 &amp; 26 to justify billing.</li> </ul> <p>Individual #8 May 2011</p>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p>

<p><b>A. Reimbursement for Supported Living Services</b></p> <p>(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.</p> <p>(2) <b>Billable Activities</b></p> <p>(a) Direct care provided to an individual in the residence any portion of the day.</p> <p>(b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community.</p> <p>(c) Any activities in which direct support staff provides in accordance with the Scope of Services.</p> <p>(3) Non-Billable Activities</p> <p>(a) The Supported Living Services provider shall not bill DD Waiver for Room and Board.</p> <p>(b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services.</p> <p>(c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.</p>	<ul style="list-style-type: none"> <li>• The Agency billed 12 units of Supported Living from 5/20/2011 through 5/31/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 5/20, 21, 22, 27, 28 &amp; 29 to justify billing.</li> </ul> <p>June 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 30 units of Supported Living from 6/1/2011 through 6/30/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 6/17, 19, 24, 25 &amp; 26 to justify billing.</li> </ul> <p>Individual #9</p> <p>April 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 30 units of Supported Living from 4/1/2011 through 4/30/2011. Documentation received accounted for 29 units. Additionally, documentation did not contain a signature/authenticated name of the staff providing the service on 4/1, 2, 15, 16, 17, 23, 24, 29 &amp; 30 to justify billing.</li> </ul> <p>May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 13 units of Supported Living from 5/19/1/2011 through 5/31/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 5/21, 22, 27, 28 &amp; 29 to justify billing.</li> </ul> <p>June 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 30 units of Supported Living from 6/1/2011 through 6/30/2011. Documentation did not contain a signature/authenticated name of the staff providing the service on 6/3, 4, 5, 11, 12, 17, 18, 19, 24, 25 &amp; 26 to justify billing.</li> </ul>	
--	---	--

Date: November 29, 2011

To: Mr. Joe Madrid, Executive Director

Provider: Tobosa Developmental Services  
Address: 110 E. Summit  
State/Zip: Roswell, New Mexico 88203

CC: Ms. Doris Callaway, Board Chair  
3100 South Main  
Roswell, New Mexico 88203

CC (email): Ms. Rosy Rubio, Assistant Director, Tobosa Dev. Services

Region: Southeast  
Survey Date: July 18 - 20, 2011  
Program Surveyed: Developmental Disabilities Waiver  
Services Surveyed: Living Supports (Supported Living & Independent Living) & Inclusion Supports (Adult Habilitation, Community Access & Supported Employment)  
Survey Type: Routine

Dear Mr. Madrid:

The Division of Health Improvement Quality Management Bureau received, reviewed and approved the documents you submitted for your Plan of Correction. The documents you provided verified that survey Deficiencies were corrected.

**The Plan of Correction process is now complete.**

To maintain ongoing compliance with Standards and regulations, continue to use the Quality Assurance/Quality Improvement processes described in your Plan of Correction, including:

- Retraining of staff who make medication documentation, billing documentation, and/or incident reporting errors
- Quality Assurance/Quality Improvement committee to meet quarterly, and review the agency nursing department
- Agency Nurse to approve all PRN medications
- Tobosa has a system to track all state-mandated trainings required for staff. Trainings are provided monthly by an in-house trainer. In-house trainer tracks the number of times each staff member misses a particular training. Supervisors and administrators are provided this information



- Quality Assurance/Quality Improvement measures are taken on a quarterly basis by reviewing the incidents filed. Trends and patterns are measured and actions are taken by providing additional training to those employees that do not follow the process
- Monthly house checks by house manager and quarterly visits by residential supervisor reviews the storage of medications
- Quality Assurance/Quality Improvement Committee will be reviewing home sites on a quarterly basis beginning on September 17, 2011. They will review four out of the 16 homes every quarter. Reports will be written and delivered to QA lead staff for further review and any necessary actions
- Billing personnel will review, revise and return any inaccurate logs for corrections before billing for those services
- Tobosa has a procedure that "red flags" when annual examinations are required or have been performed. Every individual medical file has a chart that reflects the date of visit of every required examination and the date of any follow ups
- Tobosa has a process that requires all residential case files be reviewed quarterly by agency case records personnel. In addition, house managers are required to review case files during their monthly house check to assure that all material is up to date

Consistent implementation of your QA/QI processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer Deficiencies in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, and for the work you and your team perform.

Sincerely,



George Perrault, MBA  
Plan of Correction Coordinator

Cc: DHI  
DDSD