Date: November 30, 2010

To: Pam Lillibridge, Executive Director
Provider: Tresco, Inc.
Address: 1800 Copper Loop
State/Zip: Las Cruces, NM 88001
E-mail Address: plillibridge@trescomail.org

CC: Russell Foddrill, Board Chair
Address: 2188 Sagecrest
State/Zip: Las Cruces, New Mexico 88011
Board Chair
E-Mail Address: rfoddrill@firstamb.com

Region: Southwest
Survey Date: October 18 – 21, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living & Independent Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Survey Type: Routine
Team Leader: Valerie V. Valdez, MS, Healthcare Program Manager/Healthcare Surveyor
Division of Health Improvement/Quality Management Bureau

Team Members: Scott Good, MRC, CRC, Deputy Bureau Chief/Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Cynthia Nielsen, RN, MSN, ONC, CCM, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Florie Alire, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Dave Brunson, LBSW, DDSD Community Inclusion Coordinator, Developmental Disabilities Supports Division

Dear Ms. Lillibridge;

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 Compliance Determination:
The Division of Health Improvement is issuing your agency a determination of "Non-Compliance with Conditions of Participation."

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 working days of the receipt of this letter:

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

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

Upon notification from QMB that your Plan of Correction has been approved, you must implement all remedies and corrective actions within 45 working days. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as all remedies must still be completed within 45 working 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 working days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

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

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 working 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,

Valerie V. Valdez, M.S.

Valerie V. Valdez, M.S.
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	October 18, 2010
Present:	**Tresco, Inc** Tim Gilliland, Director of Community Services Shelby Heiden, Training Coordinator **DOH/DHI/QMB** Valerie V. Valdez, MS, Team Lead/Healthcare Program Manager/Healthcare Surveyor Scott Good, MRC, CRC, Deputy Bureau Chief Cynthia Nielsen, RN, MSN, ONC, CCM, Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor Florie Alire, RN, Healthcare Surveyor Deb Russell, BS, Healthcare Surveyor **DDSD – Southwest Regional Office** Dave Brunson, LBSW, DDSD Community Inclusion Coordinator
Exit Conference Date:	October 21, 2010
Present:	**Tresco, Inc** Tim Gilliland, Director of Community Services Joel Jaire, Community Living Services Assistant Program Manager Dona Nelson, Community Living Services Program Manager J. Maureen Gant, Program Support Manager Nicole Johnson, Quality Enhancement Systems Manager Suzanne Purcell, Community Living Services Supervisor Waunita Brown, Community Living Services Supervisor Forrest F. McDaniel, Community Living Services Supervisor Alyson Parra, Community Living Services Scheduling Coordinator Michelle Baldwin, Community Living Services Supervisor Joyce Weeks, Community Living Services Supervisor Roxanne Sanchez, Community Living Services Supervisor Marilyn Kirby, Quality Advisor Steve Adams, Assistant Vocational Manager Shelby Heiden, Training Coordinator **DOH/DHI/QMB** Valerie V. Valdez, MS, Team Lead/Healthcare Program Manager/Healthcare Surveyor Scott Good, MRC, CRC, Deputy Bureau Chief Cynthia Nielsen, RN, MSN, ONC, CCM, Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor Florie Alire, RN, Healthcare Surveyor Deb Russell, BS, Healthcare Surveyor **DDSD – Southwest Regional Office** Dave Brunson, LBSW, DDSD Community Inclusion Coordinator Paul Schwalje, Regional Offices Bureau Chief Scott Doan, Southwest Regional Director
Total Homes Visited	Number: 8
❖ Supported Homes Visited	Number: 8 (5 Homes were the residence for multiple Individuals)
Administrative Locations Visited	Number: 2 (Las Cruces, New Mexico & Socorro, New Mexico)
Total Sample Size	Number: 25 4 - *Jackson* Class Members

		21 - Non-*Jackson* Class Members 16 - Supported Living 6 - Independent Living 20 - Adult Habilitation 5 - Community Access 16 - Supported Employment
Persons Served Interviewed	Number:	15
Persons Served Observed	Number:	10 (6 Individuals were not available during on-site survey, 3 Individuals answers could not be understood by the Surveyor & 1 Individual did not want to participate in the Interview process.)
Direct Service Personnel Interviewed	Number:	26
Records Reviewed (Persons Served)	Number:	25

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

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

Attachment A

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

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. Requests for technical assistance must be requested through your DDSD 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
    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 working 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.

Attachment B

QMB Scope and Severity Matrix

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

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

Scope and Severity Definitions:

- Isolated:

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

- Pattern:

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

- Widespread:

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

QMB Determinations of Compliance

- "Substantial Compliance with Conditions of Participation"

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

- "Non-Compliance with Conditions of Participation"

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

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

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

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

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

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

Attachment C

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

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

Instructions:

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

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

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

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

The following limitations apply to the IRF process:

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

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

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

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

Agency: **Tresco, Inc. - Southwest Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living & Independent Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Routine Survey
Date of Survey: **October 18 – 21, 2010**

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A08 Agency Case File	**Scope and Severity Rating: A**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 3 of 25 individuals. Review of the Agency individual case files found the following items were not found, incomplete, and/or not current: • **ISP Teaching & Support Strategies** ◦ Individual #2 - TASS not found for: ◦ Outcome Statement # 3 ➢ "will choose date/place." ➢ "will take a trip." • **Annual Physical** (#8 & 10) • **Dental Exam** ◦ Individual #8 - As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #10 - As indicated by collateral documentation reviewed, the exam was completed on 5/11/2010. No evidence of exam results was found. • **Vision Exam** ◦ Individual #8 - As indicated by the DDSD file matrix, Vision Exams are to be conducted annually. No evidence of exam was found.		

all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.	◦ Individual #10 - As indicated by the documentation reviewed, exam was scheduled for 7/2009. No evidence found to verify visit was completed. • **Auditory Exam** ◦ Individual #10 - As indicated by collateral documentation reviewed, the exam was completed on 10/2008. No evidence of exam results was found.		

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and	Medication Administration Records (MAR) were reviewed for the months of June, July & August 2010. Based on record review, 6 of 25 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #9 August 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Gabapentin 300mg (3 times daily) – Blank 8/16 (12 PM) Individual #17 August 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Risperdal 0.5mg (2 times daily) – Blank 8/31 (8 PM) • Sennakot 8.6/50mg (2 times daily) – Blank 8/31 (8 PM) Individual #19 June 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Clonazepam 0.5mg (1 time daily) – Blank 6/28 (2 PM) Individual #20 August 2010 Medication Administration Records contained missing entries. No documentation found		

(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff	indicating reason for missing entries: • Nasonex 50mcg (1 times daily) – Blank 8/31. Individual #21 June 2010 Medication Administration Records did not contain the strength of the medication which is to be given: • Calcium With Vitamin D (2 times daily) July 2010 Medication Administration Records did not contain the strength of the medication which is to be given: • Calcium With Vitamin D (2 times daily) August 2010 Medication Administration Records did not contain the strength of the medication which is to be given: • Calcium With Vitamin D (2 times daily) Individual #23 July 2010 As indicated by the Medication Administration Records the individual was to take Prednisone 20mg for 7 days. According Medication Administration Record medication was only taken on July 8 & 9, 2010.		

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 # 1A09.1 Medication Delivery - PRN Medication	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 3 of 25 Individuals. Individual #20 July 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 600mg – PRN – 7/12 (given 1 time) Individual #23 July 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Albuterol .083% - PRN – 7/7, 26 & 29 (given 1 time) • Ibuprofen 200mg – PRN – 7/20 (given 1 time) Individual #25 August 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Bisacodyl suppository – PRN – 8/12 (given 1 time) • Ibuprofen 200mg – PRN – 8/1, 4 & 9 (given 1 times) • Triazolam 0.25mg – PRN – 8/4 & 9 (given 1 times) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Bisacodyl suppository – PRN – 8/12 (given 1		

(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued	time) • Ibuprofen 200mg – PRN – 8/1, 4 & 9 (given 1 times) • Triazolam 0.25mg – PRN – 8/4 & 9 (given 1 times)		

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

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

(References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications). a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).			

Tag # 1A09.2 Medication Delivery - PRN Nurse Approval	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. **Department of Health** **Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006** **F. PRN Medication** 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to	Based on record review and interview, the Agency failed to maintain documentation of PRN usage as required by standard for 1 of 25 Individuals. Individual #25 August 2010 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: • Bisacodyl 1 suppository – PRN – 8/12 (given 1 time) • Ibuprofen 200mg – PRN – 8/1, 4 & 9 (given 1 times) • Triazolam 0.25mg – PRN – 8/4 & 9 (given 1 times)		

assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual. 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of			

consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications). a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.). **NMAC 16.19.11.8 MINIMUM STANDARDS:** **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications.			

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 25 of 196 Direct Service Professionals. Review of Direct Service Professional training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Foundation for Health & Wellness (DSP #146 & 147) • Person-Centered Planning (1-Day) (DSP #209) • First Aid (DSP #64 & 67) • CPR (DSP #64, 67, 181 & 192) • Assisting With Medication Delivery (DSP #49, 56, 59, 64, 70, 81, 107, 113, 121, 142, 148, 158, 159, 173, 176, 178, 192, 196 & 210) • Teaching & Support Strategies (DSP #136)		

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		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **F. Qualifications for Direct Service Personnel:** The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency: (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy	Based on interview, the Agency failed to ensure that training competencies were met for 7 of 26 Direct Service Professionals. **When DSP were asked if the individual had a Positive Behavioral Crisis Plan and what the plan covered, the following was reported:** • DSP #214 stated, "I'm unfamiliar with the BT Crisis Plan." According to the Individual Specific Training Section of the ISP, the individual has Positive Behavioral Crisis Plan. (Individual #2) **When DSP were asked if they had received training regarding the individual's Seizure Crisis Plan, the following was reported:** • DSP #237 stated, "No seizure crisis plan developed yet."According to the IST section of the ISP the Individual is to have a Seizure Crisis Plan. (Individual #10) **When DSP were asked if the Individual had a Meal Time Plan and what the plan covered, the following was reported:** • DSP #198 stated, "No." As indicated by the Individual Specific Training section of the ISP, the individual has a Meal Time Plan. (Individual #5) • DSP #53 stated, "No." As indicated by the Individual Specific Training section of the ISP, the individual has a Meal Time Plan. (Individual #5) **When DSP were asked if the Individual had any food and/or medication allergies that could be potentially life threatening, the following was reported:**		

Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and (5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support. (6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows: (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff.	• DSP #99 reported the Individual had no allergies or adverse reaction. Per ISP the Individual is allergic to "bee stings and possible allergic reactions to Strattera, Abilify & Ritalin." (Individual #12) • DSP #130 stated, "Not that I am aware of, nurse gives meds." Per documentation reviewed the Individual is allergic to Penicillin & Augmentin. (Individual #23)		

Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: E		
7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: **A. Duty To Report:** **(1)** All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. **(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: **(a)** an environmental hazardous condition, which creates an immediate threat to life or health; or **(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. **(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. **B. Notification**: **(1) Incident Reporting:** Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.	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 5 of 29 individuals. Individual #20 • Incident date 5/9/2010. Allegation was Emergency Services. Incident report was received 5/18/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #26 • Incident date 2/23/2010. Allegation was Neglect. Incident report was received 2/25/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." • Incident date 5/12/2010. Allegation was Neglect & Exploitation. Incident report was received 5/13/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." • Incident date 6/24/2010. Allegation was Neglect. Incident report was received 7/23/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #27 • Incident date 5/12/2010. Allegation was Neglect & Exploitation. Incident report was received 5/13/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." • Incident date 6/24/2010. Allegation was Neglect. Incident report was received 7/23/2010. Late Reporting. IMB Late & Failure Report indicated		

	incident of Neglect was “Confirmed.” Individual #28 • Incident date 5/12/2010. Allegation was Neglect & Exploitation. Incident report was received 5/14/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was “Confirmed.” • Incident date 6/24/2010. Allegation was Neglect. Incident report was received 7/23/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was “Confirmed.” Individual #29 • Incident date 8/1/2010. Allegation was Neglect. Incident report was received 8/10/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was “Confirmed.”		

Tag # 1A28.2 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: D		
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **E. Consumer and Guardian Orientation Packet:** Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 1 of 25 individuals. • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#4)		

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: D		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 3 of 25 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Independent Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #17 • None found for August 2010 **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #16 • Action step: “Taking pictures” is to be completed 2 times per month. Outcome #4 was not being completed at the required frequency. Individual #17 • None found for 6/2010 – 8/2010. Individual #24 • Outcome #2 “I will learn 50 Spanish words by next year” was not being completed at the required frequency. **Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #24 • None found regarding: “I will learn the routine for the new buildings” Action step #1 “Follow instructions from job coach” for 2/2010 – 9/2010.		

Tag # 1A33 Board of Pharmacy - Med Storage	Scope and Severity Rating: A		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **E. Medication Storage:** 1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee. 2. Drugs to be taken by mouth will be separate from all other dosage forms. 3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature. 4. Separate compartments are required for each resident's medication. 5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day. 6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist. **8. References** A. Adequate drug references shall be available for facility staff **H. Controlled Substances (Perpetual Count Requirement)** 1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance, indicating the following information: a. date b. time administered c. name of patient	Based on observation, the Agency failed to ensure proper storage of medication for 2 of 25 individuals. Observation included: Individual #5 • Dulcolax expired 1/2010. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Saline Nasal Spray expired 6/2010. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Triple Antibiotic Ointment expired 1/2010. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. Individual #15 • Nystatin Powder expired 5/2010. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.		

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 # 5I02 Community Inclusion: Scope of Services	Scope & Severity Rating: A		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 II.SCOPE OF COMMUNITY INCLUSION SERVICES:** Community Inclusion Services support measurable individual progress as specified in the ISP, including the individual's personal definition of a meaningful day. The outcome of Community Inclusion Services is that the individual becomes an integral part of his/her community in the manner desired by the individual. **A. Community Inclusion Services:** Community Inclusion Services shall be provided in accordance with each individual's ISP, needs and preferences, and shall consist of the following activities, as appropriate to the individual, including, but not limited to: (1) Participation in the IDT to assure that ISPs are adequate to define what constitutes a meaningful day for the individual, as well as to guide development of the quantity and quality of the individual's daily activities and experiences; (2) Action by provider staff resulting in community membership, community connections, valued roles, and equitably paid employment; (3) Service delivery that includes, throughout the course of each day, individual choice-based options and age appropriate skill building activities as specified in the individual's ISP Action Plan; (4) Staff training and use of assessment tools to assure knowledge of the individual and that person's ISP; (5) Direct observation, support and mentoring of	Based on Interview the Agency failed to ensure Community Inclusion Services in accordance with each individual's ISP for 2 of 25 Individuals receiving Community Inclusion Services. **When Individuals were asked if they trusted & felt safe with their "staff" (Direct Service Professionals), the following was reported:** • Individual #8 reported there were issues with the staff texting while driving. The Individual did not identify the staff member. • Individual #22 stated, "staff is different too often."		

the quality of daily experiences for individuals receiving Community Inclusion Services; (6) Identification of barriers to implementing the ISP Action Plan in the community; (7) Implementation of strategies to address these barriers and documentation of what solutions were effective; (8) Arranging for and/or provision of transportation needed during the delivery of Community Inclusion Services; and (9) Documentation of all activities provided under paragraph (1) - (8) of this subsection. II A.			

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Scope and Severity Rating: A		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **E. Provider Agency Reporting Requirements:** All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD.	Based on record review, the Agency failed to complete quarterly reports as required for 2 of 25 individuals receiving Community Inclusion services. **Supported Employment Quarterly Reports** • Individual #3 - None found for 6/2010 – 8/2010. • Individual #4 - None found for 2/2009 - 9/2010.		

Tag # 6L04 (CoP) CL Scope of Service	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. II. SCOPE OF COMMUNITY LIVING SERVICES**. **A**. The scope of Community Living Services includes, but is not limited to the following as identified by the IDT: (1) Assist with money management, including financial record keeping; (2) Assistance to attain and maintain safe and sanitary living conditions that may include general housekeeping, shopping, washing and drying laundry; (3) Assistance to maintain activities of daily living such as bathing, eating, meal preparation, dressing, and individual hygiene; (4) Assistance with mobility and orientation in community integration, access and utilization of natural supports (5) Assistance in developing and maintaining social, spiritual and individual relationships, to include the development of generic and natural supports of his or her choosing; (6) Assistance to access recreational and leisure activities; (7) Assistance in access to training and educational opportunities on self-advocacy and sexuality; (8) Implementation of the ISP Therapy, Meal-time, Positive Behavioral Supports, Health Care, and Crisis Prevention/Interventions Plans, if applicable; (9) Assistance in developing health maintenance supports, as well as monitoring the effectiveness of such supports; (10) Provide or arrange for transportation for, but not limited to, Community Inclusion, leisure and recreation activities, medical, dental, and	Based on interview, the Agency failed to provide Community Living Services within the Scope of Service for 1 of 22 individuals. **When Individuals were asked if they felt safe and comfortable in their homes, the following was reported:** • Individual #20 stated, “No, I live in the projects,” The Individual was not willing to explain their situation further.		

therapy appointments; (11) Assistance in medication management and pharmacy needs in accordance with the DDSD's Medication Assessment and Delivery Policy; (12) Assist the individual as needed, in coordination with the designated healthcare coordinator and others on the IDT, with access to medical, dental, therapy, nutritional, behavioral and nursing practitioners and in the timely implementation of healthcare orders, monitoring and recording of therapeutic plans or activities as prescribed, to include: health care and crisis prevention/ intervention plans; (13) Support individuals to participate in the development of house rules, schedules and planned activities; and (14) For individuals with a HAT score of 5 or 6, the agency nurse shall participate in the annual ISP meeting and any other IDT meetings called to address a change in health condition/new diagnosis. Such participation will preferably occur in person or by phone, but if that is not possible, may occur via provision of information to the team prior to the meeting with follow up contact afterwards.			

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6	Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 3 of 22 individuals receiving Community Living Services. The following was not found, incomplete and/or not current: • **Annual Physical** (#24) • **Dental Exam** ◦ Individual #24 - As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of exam was found. • **Vision Exam** ◦ Individual #18 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #23 - As indicated by the documentation reviewed, exam was completed on 7/13/2009. Follow-up was to be completed in 1 year. No evidence of follow-up found. ◦ Individual #24 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found. • **Auditory Exam** ◦ Individual #23 - As indicated by the documentation reviewed, exam was completed on 2/3/2009. Follow-up was to be completed in 1 year. No evidence of follow-up found. • **Abnormal Involuntary Movement Screening and/or Tardive Dyskinesia Screenings** ◦ None found 10/2009 – 10/2010 for Reglan (#23)		

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

Tag # 6L14 Residential Case File	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 13 of 16 Individuals receiving Supported Living Services. The following was not found, incomplete and/or not current: • **Current Emergency & Personal Identification Information** ° Did not contain Individual's current address (#2) • Annual ISP (#5 & 7) • Individual Specific Training Section of ISP (#5 & 7) • Positive Behavioral Plan (#11) • Positive Behavioral Crisis Plan (#2) • Speech Therapy Plan (#1) • **Special Health Care Needs** ° Communication Plan (#11) • **Crisis Plan** ° Allergies (#2, 5 & 16) ° HIV (#19) ° Respiratory (#19) • **Progress Notes/Daily Contacts Logs:** ° Individual #5 - None found for October 1 – 16, 2010 ° Individual #9 - None found for October 1 – 17, 2010. ° Individual #11 - None found for October 1 – 16, 2010		

a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations…	° Individual #13 - None found for October 1 – 16, 2010 ° Individual #15 - None found for October 1 – 16, 2010. ° Individual #16 - None found for October 1 – 16, 2010. ° Individual #19 - None found for October 1 – 16, 2010 ° Individual #22 - None found for October 1 – 17, 2010. ° Individual #23 - None found for October 1 – 16, 2010 ° Individual #25 - None found for October 1 – 16, 2010 • **Data Collection/Data Tracking:** ° Individual #5 - None found for October 1 – 16, 2010 ° Individual #16 - None found for October 1 – 16, 2010 ° Individual #22 - None found for October 1 – 17, 2010. ° Individual #25 - None found for October 1 – 16, 2010 • **Progress Notes written by DSP and/or Nurses regarding Health Status:** ° Individual #9 - None found for October 1 – 17, 2010.		

Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports)	Scope and Severity Rating: A		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **D. Community Living Service Provider Agency Reporting Requirements:** All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation: (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members.	Based on record review, the Agency failed to complete written quarterly status reports for 1 of 22 individuals receiving Community Living Services. **Support Living Annual Assessment** • Individual #4 - None found for 2/2009 – 3/2010.		

Tag # 6L25.1 (CoP) Residential Reqts. (Physical Environment - Supported Living & Family Living)	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services** (2) Overall each residence shall maintain basic utilities, i.e., gas, power, water, telephone at the residence and shall maintain the physical environment in a safe and comfortable manner for the individuals. (3) Each individual shall have access to all household equipment and cleaning supplies unless precluded by his or her ISP. (4) Living and Dining Areas shall (a) Provide individuals free use of all space with due regard for privacy, personal possessions and individual interests; (b) Maintain areas for the usual functions of daily living, social, and leisure activities in a clean and sanitary condition; and (c) Provide environmental accommodations based on the unique needs of the individual. (5) Kitchen area shall: (a) Possess equipment, utensils, and supplies to properly store, prepare, and serve at least three (3) meals a day; (b) Arrangements will be made, in consultation with the IDT for environmental accommodations and assistive technology devices specific to the needs of the individual(s); and (c) Water temperature is required to be maintained at a safe level to both prevent	Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard, which maintains a physical environment which is safe and comfortable for 1 of 8 Supported Living residences. **Supported Living Requirements:** During on-site visit (10/19/2010), surveyors observed the following: A sign was observed above kitchen sink on a light outlet with no light blub which stated do not use, water comes out when it rains. When Surveyor asked about the sign, DSP #47 reported maintenance was aware of the problem. No evidence was found that it was or is in the process of being corrected. (Individual #6)		

injury and ensure comfort. (6) Bedroom area shall: (a) At a maximum of two (2) individuals share, with mutual consent, a bedroom and each individual has the right to have his or her own bed; (b) All bedrooms shall have doors, which may be closed for privacy (c) Physical arrangement of bedrooms compatible with the physical needs of the individual; and (d) Allow individuals the right to decorate his or her bedroom in a style of his or her choice consistent with a safe and sanitary living conditions. (7) Bathroom area shall provide: (a) For Supported Living, a minimum of one toilet and lavatory facility for every two (2) individuals with Developmental Disabilities living in the home; (b) Reasonable modifications or accommodations, based on the physical needs of the individual (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.): (i) Toilets, tubs, showers used by the individual(s) provide for privacy; designed or adapted for the safe provision of personal care; and (ii) Water temperature maintained at a safe level to prevent injury and ensure comfort.			

ADDITIONAL FINDINGS: Reimbursement Deficiencies

BILLING
TAG #1A12

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

B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:

(1) Date, start and end time of each service encounter or other billable service interval;
(2) A description of what occurred during the encounter or service interval; and
(3) The signature or authenticated name of staff providing the service.

Billing for Community Living (Supported Living & Independent Living) and Community Inclusion (Adult Habilitation, Community Access & Supported Employment) services was reviewed for 25 of 25 individuals. Progress notes and billing records supported billing activities for the months of June, July and August 2010.

Date: January 12, 2011

To: Pam Lillibridge, Executive Director
Provider: Tresco, Inc.
Address: 1800 Copper Loop
State/Zip: Las Cruces, NM 88001
E-mail Address: plillibridge@trescomail.org

Region: Southwest
Survey Date: October 18 – 21, 2010
Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Ms. Lillibridge,

Your request for a Reconsideration of Findings was received on December 13, 2010. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A09.1
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, deficiencies noted in tag 1A09.1 regarding Individual #20 will be removed; the remainder of the deficiencies disputed by you were not cited under the tag 1A09-Routine Medication in the original Report of Findings, therefore can not be challenged. The remaining citations noted in this tag were not disputed. The scope and severity rating for this tag will remain "E."

Regarding Tag # 1A20
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the document request form specific to training, the documents needed to demonstrate trainings had occurred were requested from and signed by Maureen Gant on 10/20/10 and not received prior to the end of the survey. The remaining citations noted in tag 1A20 were not disputed. The scope and severity rating will remain "D."

Regarding Tag # 1A26
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, and the Individual Service Plan for Individual #2, the Individual was required to have a Positive Behavioral Crisis Plan. This was not an error on the part of the Survey Team, but the IDT and Tresco for not assuring the accuracy of the ISP document and its implementation. The remaining citations noted in tag were not disputed. The scope and severity rating for this tag will remain "E."

Regarding Tag # 1A27
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the documentation the findings will remain. As instructed during the on-site survey, if Tresco has evidence the citations from the DHI/Incident Management Bureau is incorrect, they should dispute the citation with the IMB, specifically Alice Maes, IMB Chief. No evidence of IMB rescinding their determination was submitted as part of this IRF request. The remaining citations noted in tag were not disputed. The scope and severity rating for this tag will remain "E."

Regarding Tag # 1A33
Determination: The IRF committee is removing the original finding in the report of findings. Based on documentation supplied, deficiencies noted in tag 1A33 regarding separation of medications will be removed.

Regarding Tag # 5I02
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the Individual interview conducted the *opinion* of the Individual served is, "staff is different too often," not whether staffing patterns are deficient. This committee suggests you speak to the Individual and determine if the staffing patterns or staff turnover in their home is a problem. The scope and severity rating for this tag will remain "A."

Regarding Tag # 6L04
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the Individual interview conducted the *opinion* of the Individual served is, "…I live in the projects." This committee suggests you speak to the Individual and determine if the Individual feels safe in their current living situation and determine the appropriateness of a change in living situations with the Individual and their IDT if the Individual served feel they live in an unsafe environment. The scope and severity rating for this tag will remain "D."

Regarding Tag # 6L14
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied the Residential Interview and Case File Review Tool, the documents were requested from and signed by J. Marquez on 10/19/10 at 4:00 PM and not received prior to the end of the survey. The remaining citations noted in tag 6L14 were not disputed. The scope and severity rating will remain "E."

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

Thank you.
Respectfully,

Dan Maxwell
Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair