Date:	May 3, 2010
To:	Dayna Altom, Executive Director
Provider:	Wilson Residential Care Services
Address:	1706 Washington, NE
State/Zip:	Albuquerque, New Mexico 87110
E-mail Address:	wilsonrcs@q.com
CC:	Dee Burns, Board Chair
Address:	1706 Washington, NE
State/Zip	Albuquerque, New Mexico 87110
E-Mail Address:	wilsonrcs@q.com
Region:	Metro
Survey Date:	March 29 - 31, 2010
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Community Living (Supported Living) & Community Inclusion (Adult Habilitation)
Survey Type:	Focused
Team Leader:	Stephanie R. Martinez de Berenger, MPA, CDF, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Cynthia Nielsen, RN, MSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau.

Dear Ms. Altom,

The Division of Health Improvement Quality Management Bureau has completed a focused survey of the service 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. The specific focus of this survey was to determine compliance with the DDSD Training (i.e. DDSD Core training, CPR/1st Aid, Incident Management, etc.); compliance with Caregiver Criminal History Screening and the Employee Abuse Registry and Nursing/Medical oversight, as required by standard.

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

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

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

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

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

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

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

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

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

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

Please call the Team Leader at 505-690-7285, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Stephanie R. Martinez de Berenger, MPA, GCDF

Stephanie R. Martinez de Berenger, M.P.A., CDF
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	March 29, 2010
Present:	**Wilson Residential Care Services** Dee Burns, Administrator Denice Wilson, Administrator **DOH/DHI/QMB** Stephanie R. Martinez de Berenger, MPA, CDF, Team Lead/Healthcare Surveyor Cynthia Nielsen, RN, MSN, Healthcare Surveyor
Exit Conference Date:	March 31, 2010
Present:	**Wilson Residential Care Services** Dee Burns, Administrator Denice Wilson, Administrator **DOH/DHI/QMB** Stephanie R. Martinez de Berenger, MPA, CDF, Team Lead/Healthcare Surveyor Cynthia Nielsen, RN, MSN, Healthcare Surveyor Marti Madrid, LBSW, Healthcare Surveyor
Homes Visited	Number: 4
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 6 0 - Jackson Class Members. 6 - Non-Jackson Class Members 6 - Supported Living 2 - Adult Habilitation
Persons Served Interviewed	Number: 5
Persons Served Observed	Number: 1 (Individual declined to be interviewed)
Administrative Files Reviewed	• DDSD Training Compliance Records • Caregiver Criminal History Screening Records • Employee Abuse Registry • Employee Training Records

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

Attachment A

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8647.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency ("Responsible Party") and by WHEN ("Date Due").
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues to prevent the Deficiency from reoccurring, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency's Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to George.Perrault@state.nm.us, by fax (505-222-8661), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been "Approved" or "Denied".
- Whether your POC is "Approved" or "Denied", you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is "Denied" it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- The following Deficiencies must be corrected within the deadlines below (after receipt of your Survey Report):
- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8647 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.
- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by-case basis.
- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual #s.
- Do not submit original documents, hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Attachment B

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

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

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

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

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

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

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

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

Attachment C

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

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

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

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

The following limitations apply to the IRF process:

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

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

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

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

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

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

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

Agency: **Wilson Residential Care Services - Metro Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living) & Community Inclusion (Adult Habilitation)
Monitoring Type: Focused Survey
Date of Survey: **March 29 - 31, 2010**

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
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	Medication Administration Records (MAR) were reviewed for the months of December 2009, January 2010 & February 2010. Based on record review, 4 of 6 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #1 December 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Tums Ultra Chewable (1 time daily) January 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Tums Ultra Chewable (1 time daily) • Ativan 1 mg (3 times daily) • Thorazine 25mg (2 times daily) • Chlorpromzine 25 mg (2 times daily) February 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Antacid (1 time daily)		

prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the 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;	Individual #2 December 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Cogentin 0.5MG Tablet (1 time daily) – Blank 12/14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31. January 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries • Cogentin 0.5MG Tablet (1 time daily) – Blank 1/1, 2, 3, 4, 5, 6, 7, 8, 9 & 10. Medication Administration Records did not contain the following medications. No Physician's Orders were found for the following medications: • Sudafed 30mg • Pepto Bismol Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard: • Sudafed 30mg • Pepto Bismol Individual #3 February 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Vitamin B12 1000MCG (1 time daily) • Claritin 10MG (1 time daily) • K-DUR 10MEQ SA (1 time daily) • Glucosamine – Chondroitin (1 time daily) • Vitamin D 1,000 units SOF (1 time daily) • Calcium 600MG (1 time daily) • Fish Oil 1,000 MG (2 times daily)		

(iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period.	• Omeprazole DR 20 (1 time daily) • Levetiracheta 250 (2 times daily) • Valium 5MG TABLET (2 times daily) March 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries • Calcium 600MG W/D (2 time daily) – Blank 3/27/2010 (PM) • Fish Oil 1,000MG (2 times daily) - Blank 3/27/2010 (PM) • Avelox 400 MMG (1 time daily) – Blank 3/11 & 12, 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Metamucil • Miralax Medication Administration Records did not contain the dosage for the following medications: • Miralax Medication Administration Records did not contain the route of administration for the following medications: • Metamucil • Miralax Medication Administration Record did not contain the specific time(s) the medication should be given for the following medications: • Metamucil • Miralax Individual #5 December 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:		

	• Flovent HFA 44 MCG INHALE (2 times daily) – Blank 12/5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15,16, 17 (AM & PM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Geodon 40MG (2 times daily) • Depakote ER 250MG (2 times daily) January 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries • Flovent HFA 44 MCG INHALE (2 time daily) – Blank 1/1, 2 & 3 (8:00AM & 5:00PM). Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Abilify 15 MG (1 time daily) • Depakote ER 250MG (2 times daily) February 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries • Levothyroxine 137MCG (1 time daily) – Blank 2/1, 2 & 3 • Desogen 28 Day (1 time daily) – Blank 2/15, 16 & 19 • Cogentin 1MG (2 times daily) – Blank 2/11 & 14 (8:00AM) & 2/13, 16 & 17. (5:00PM) • Depakote ER 250MG (2 times daily) – Blank 2/11, 13 & 14 (8:00 AM) • Depakote ER 500 MG (1 time daily) – Blank		

	2/22, 23 & 24 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Abilify 15 MG (1 time daily)		

Tag # 1A09 Medication Delivery - PRN Medication	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 5 of 6 Individuals. Individual #1 December 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Nyquil Vicks Liquid Caps (PRN) Dayquil Vicks Cold/Flu (PRN) Medication Administration Records did not contain the dosage for the following medications: • Nyquil Vicks Liquid Caps (PRN) • Dayquil Vicks Cold/Flu (PRN) January 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Nyquil Vicks Liquid Caps (PRN) • Dayquil Vicks Cold/Flu (PRN) Medication Administration Records did not contain the dosage for the following medications: • Nyquil Vicks Liquid Caps (PRN) • Dayquil Vicks Cold/Flu (PRN) February 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Aleve 220 MG – PRN – 02/06 (given 2 times) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Aleve 220 MG – PRN – 02/06 (given 2 times)		

(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	Medication Administration Records did not contain the circumstance for which the medication is to be used: • Lorazepam .5MG - (PRN) Individual #2 January 2010 Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard: • Sudafed 30mg • Pepto Bismol Individual #3 February 2010 Medication Administration Records did not contain the circumstance for which the medication is to be used: • Diazepam 0.5MG (PRN) Individual #5 February 2010 Medication Administration Records did not contain the circumstance for which the medication is to be used: • Ibuprofen 200MG (PRN) Individual #6 December 2009 Medication Administration Records did not contain the dosage for the following medications: • GAS - X (PRN) Medication Administration Records did not contain the route of administration for the following medications: • GAS – X (PRN) February 2010 Medication Administration Records did not		

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.	contain the exact amount to be used in a 24 hour period: • GAS - X (PRN) Medication Administration Records did not contain the dosage for the following medications: • GAS - X (PRN) Medication Administration Records did not contain the route of administration for the following medications: • GAS – X (PRN)		

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 # 1A20 DSP Training Documents	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff…	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 10 of 20 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #40 & 42) • Basic Health/Orientation (DSP #41 & 42) • Person-Centered Planning (1-Day) (DSP #42, 53 & 54) • First Aid (DSP #40, 42, 45, 46, 47, 54 & 55) • CPR (DSP #40, 42, 45, 46, 47, 54, & 55) • Assisting With Medication Delivery (DSP #42, 47 & 53) • Rights & Advocacy (DSP #40 & 52) • Level 1 Health (DSP #40 & 52) • Teaching & Support Strategies (DSP #40 & 52) • Positive Behavior Supports Strategies (DSP #40 & 52) • Participatory Communication & Choice Making (DSP #40 & 52)		

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: E		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:** **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11** **DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.	Based on record review, the Agency failed to maintain documentation indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 12 of 20 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** • #40 – Date of hire 02/25/09 • #42 - Date of hire 08/25/09 • #46 – Date of hire 11/12/09 • #47 – Date of hire 12/16/09 • #48 – Date of hire 05/13/09 • #49 – Date of hire 07/03/09 • #50 – Date of hire 07/11/09 • #53 – Date of hire 12/16/09 • #54 - Date of hire 12/16/09 • #55 – Date of hire 11/13/09 • #57 – Date of hire 02/13/09 • #58 - Date of hire 09/05/09		

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E		
NMAC 7.1.12.8 **REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED**: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.	Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 9 of 20 agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** • #42 – Date of hire 08/25/09. Completed 10/15/09. • #45 – Date of hire 11/18/09. Completed 11/20/09. • #46 – Date of hire 11/18/09. Completed 11/20/09. • #48 - Date of hire 05/13/09. Completed 11/25/09. • #49 – Date of hire 07/03/09. Completed 11/24/09. • #50 – Date of hire 07/11/09. Completed 11/25/09. • #52 – Date of hire 03/15/09. Completed 11/25/09. • #55 – Date of hire 11/24/09. Completed 11/24/09. • #59 – Date of hire 03/23/10. Completed 03/31/09.		

E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1.IV. General Provider Requirements.** **D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.			

Tag # 1A36 SC Training	Scope and Severity Rating: A		
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;…	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 1 Service Coordinators. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed: • Positive Behavior Supports Strategies (SC #60)		