Date: May 14, 2012

To: Dee Burns, Administrator
Provider: Wilson Residential Care Services, Inc.
Address: 4623 Greene St. NW, Suite A.
State/Zip: Albuquerque New Mexico, 87114

E-mail Address: deeburnswrcs@live.com

Region: Metro
Survey Date: February 20 - 23, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Living Supports (Supported Living) & Inclusion Supports (Adult Habilitation)
Survey Type: Routine
Team Leader: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Maurice Gonzales, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Dee Burns;

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 agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Determination of Compliance:
The Division of Health Improvement, Quality Management Bureau has determined your agency is in:

Non-Compliance with all Conditions of Participation

This determination is based on non compliance with four or more CMS waiver assurances at the Condition of Participation level as well as widespread Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

Plan of Correction:
The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Your

agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

Submission of your 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)*.

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

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 to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

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

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

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). 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 505-699-0714 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,

Tony Fragua, BFA

Tony Fragua, BFA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	February 20, 2012	
Present:	**Wilson Residential Care Services, Inc.** Cameshia Fox, Executive Director **DOH/DHI/QMB** Tony Fragua, BFA, Team Lead/Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor Maurice Gonzales, BS of Health Ed., Healthcare Surveyor	
Exit Conference Date:	February 23, 2012	
Present:	**Wilson Residential Care Services, Inc.** Dee Burns, Administrator Denice Wilson, Administrator Dayna Altom, Administrator Mike Altom, Incident Management Coordinator Karen Pellerito, RN **DOH/DHI/QMB** Tony Fragua, BFA, Team Lead/Healthcare Surveyor Maurice Gonzales, BS of Health Ed., Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor	
Total Homes Visited	Number:	4
❖ Supported Homes Visited	Number:	4
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	8 8 - Non-*Jackson* Class Members 8 - Supported Living 7 - Adult Habilitation
Persons Served Records Reviewed	Number:	8
Persons Served Interviewed	Number:	4
Person Observed:	Number:	4 (4 Individuals not available during the on-site survey)
Direct Support Personnel Interviewed	Number:	8
Direct Support Personnel Records Reviewed	Number:	49
Service Coordinator Records Reviewed	Number:	1
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 Survey, your QMB Report of Findings will be sent to you via e-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 business days will be referred to the Internal Review Committee [IRC] for possible actions or sanctions).

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings. (Providers who fail to complete a POC within the 45 business days allowed shall be referred to the IRC for possible actions or sanctions.)

If you have questions about the Plan of Correction process, call the QMB Deputy Chief at 505-699-0714 or email at scott.good@state.nm.us. Requests for technical assistance must be requested through your DDSD Regional Office.

The POC process cannot resolve disputes regarding findings. 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) business days of receiving your report. 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.

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 must address the required six CMS core elements to address each deficiency of the POC:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and

sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
6. The POC must be signed and dated by the agency director or other authorized official.

The following details should be considered when developing your POC:

- 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, analyses about why targets were not met, and remedies implemented.

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) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business 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.

Initial Submission of the Plan of Correction Requirements

1. The 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. For questions about the POC process, call the QMB Deputy Chief, Scott Good at 505-699-0714 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to Scott Good, QMB Deputy Chief in any of the following ways:
    a. Electronically at scott.good@state.nm.us *(preferred method)*
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approve” or “denied.”

a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.

7. Failure to submit your POC within 10 business 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.

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 (paper hard copy or on a disc), fax, or electronically (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; Please provide copies or scanned electronic files for evidence. 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.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Deputy Chief 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.

QMB Determinations of Compliance

- "Compliance with Conditions of Participation"
  The QMB determination of "Compliance with Conditions of Participation," indicates that a provider is in compliance with all 'Conditions of Participation,' (CoP) but may have standard level deficiencies (deficiencies which are not at the condition level) out of compliance. 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 Compliance with Conditions of Participation, the provider must be in compliance with *all* Conditions of Participation.

- "Partial-Compliance with Conditions of Participation"
  The QMB determination of "Partial-Compliance with Conditions of Participation" indicates that a provider is out of compliance with one (1) to three (3) 'Conditions of Participation.' This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

  Providers receiving a repeat determination of 'Partial-Compliance' for repeat deficiencies of CoPs may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- "Non-Compliant with Conditions of Participation":
  The QMB determination of "Non-Compliance with Conditions of Participation," indicates a provider is significantly out of compliance with Conditions of Participation and/or has:
  - Four (4) Conditions of Participation out of compliance.
  - 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.

  The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

  Providers receiving a repeat determination of 'Non-Compliance' will be referred by Quality Management Bureau 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 surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated "Document Request," or "administrative Needs," etc. forms. 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 business days** of receipt of the final Report of Findings.
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.
5. If you have questions about the IRC process, email the IRF Chairperson, Scott Good at scott.good@state.nm.us for assistance.

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received within 10 business 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 DHI/QMB determination of compliance or the length of their DDSD provider contract.

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

The IRF Committee will review the request, 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: **Wilson Residential Care Services, Inc. – Metro Region**
Program: Developmental Disabilities Waiver
Service: Living Supports (Supported Living) & Inclusion Supports (Adult Habilitation)
Monitoring Type: Routine Survey
Date of Survey: **February 20 – 23, 2012**

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A08 Agency Case File	**Standard Level Deficiency**		
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,	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 2 of 8 individuals. Review of the Agency individual case files found the following items were not found, incomplete, and/or not current: • Occupational Therapy Plan (#2) • Physical Therapy Plan (#4)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, 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. **NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A			

provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.			

Tag # 1A08.1 Agency Case File - Progress Notes	Standard Level Deficiency		
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: (3) Progress notes and other service delivery documentation;	Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 3 of 9 Individuals. **Supported Living Progress Notes/Daily Contact Logs** • Individual #4 - None found for 12/27 & 28, 2011 • Individual #6 - None found for 10/8 & 9, 2011 **Adult Habilitation Progress Notes/Daily Contact Logs** • Individual #2 - None found for 10/1 & 2, 2011	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Tag # 1A32 & 6L14 ISP Implementation	*CoP Level Deficiency*		
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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. 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 6 of 8 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #2 • None found regarding: Live Outcome "… will do his own laundry with one verbal prompt in the next year" for 10/2011 - 12/2011. Individual #3 • None found regarding: Live Outcome "… would like to learn how to make Native American jewelry" for 12/2011. • None found regarding; Have Fun/Develop friendships: Outcome "… wants to maintain contact and relationship with his family" for 12/2011. Individual #5 • None found regarding: Live Outcome "… Complete 4 steps of morning routine" for 11/2011 - 12/2011.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	• None found regarding; Have Fun/Develop friendships: Outcome "…Travel to and from Family home safely" For 11/2011 – 12/2011. Individual #6 • None found regarding: Live Outcome "… will use a visual schedule 100% of the time during ISP year" for 10/2011 – 12/2011. **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #2 • None found for 10/2011. Individual #8 • None found regarding: Work/Education/Volunteer Outcome; Action Step "… will work on accessing music/downloading music onto his computer" for 10/2011 – 12/2011 • None found regarding: Work/Education/Volunteer Outcome; Action Step "… will burn CD once he has all of the music he would like to put on his CD." for 10/2011 – 12/2011 **Residential Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • None found for 2/1/2012 – 2/21/2012 Individual #8 • None found for 2/1/2012 – 2/22/2012		

Tag # 6L14 Residential Case File	Standard Level Deficiency		
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	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 8 of 8 Individuals receiving Supported Living Services. The following was not found, incomplete and/or not current: • **Current Emergency & Personal Identification Information** ◦ Did not contain Health Plan Information (#1, 3, 5 & 8) • Positive Behavioral Plan (#3) • Positive Behavioral Crisis Plan (#2, 3 & 5) • Speech Therapy Plan (#2) • Occupational Therapy Plan (#2) • Physical Therapy Plan (#6) • **Special Health Care Needs** ◦ Meal Time Plan (#2) ◦ CARMP (#2) • **Health Care Plans** ◦ Aspiration (#2) • **Crisis Plan/Medical Emergency Response Plans** ◦ Aspiration (#2) ◦ Gastrointestinal (#2 & 4) • **Progress Notes/Daily Contacts Logs:** ◦ Individual #2 - None found for 2/1/2012 – 2/13/2012	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s); (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.	◦ Individual #3 - None found for 2/1/2012 – 2/13/2012 ◦ Individual #4 - None found for 2/1/2012 – 2/13/2012 ◦ Individual #5 - None found for 2/1/2012 – 2/13/2012 ◦ Individual #7 - None found for 2/1/2012 – 2/20/2012 ◦ Individual #8 - None found for 2/1/2012 – 2/22/2012		

(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.			

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A11.1 Transportation Training	**Standard Level Deficiency**		
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… **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy** Training Requirements for Direct Service Agency Staff Policy **Eff Date:** March 1, 2007 **II. POLICY STATEMENTS:** I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be	Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 8 of 49 Direct Support Personnel. **No documented evidence was found of the following required training:** • Transportation (DSP #44, 51, 71, 72, 75 & 76) **When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported:** • DSP #43 stated, "I have not had training, but I transport consumers with someone else driving." • DSP #90 stated, "I haven't received transportation training from agency. I do transport consumers."	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)			

Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency		
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:**	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 3 of 49 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #77) • Foundation for Health & Wellness (DSP #77 & 83) • First Aid (DSP #79) • CPR (DSP #79)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served. 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 service.			

Tag # 1A22 Agency Personnel Competency	*CoP Level Deficiency*		
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;	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency failed to ensure that training competencies were met for 3 of 8 Direct Support Personnel. **When DSP were asked if the Individual had Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:** • DSP #47 stated, "Seizures; only plans in the book." According to the Individual's eCHAT, the Individual has Crisis Plans/Medical Emergency Response Plan for Aspiration. (Individual #2) • DSP #87 stated, "He has seizures and aspiration." According to the Individual's eCHAT, the Individual has Crisis Plans/Medical Emergency Response Plan for Diabetes, Respiratory & Falls. (Individual #8) **When DSP were asked what to do if the Individual had a seizure, the following was reported:** • DSP #87 stated, "He does not have a crisis plan for seizures." According to the individual's eCHAT, the individual has Crisis Plans/Medical Emergency Response Plan for Seizures. Review of the Healthcare Plan indicated DSP are to use the Vagus Nerve Stimulator. Staff was unable to describe what steps to take when they had to use the individual's Vagus Nerve Stimulator (VNS). (Individual #8)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and (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.**	**When DSP were asked if the Individual had any food and/or medication allergies that could be potentially life threatening, the following was reported:** • DSP #90 stated, "Allergic to corn and avocados no medication allergies". Per eCHAT the individual is also allergic to melons. (Individual #6)		

March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff.			

Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	*CoP Level Deficiency*		
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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. 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 21 of 49 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** **Direct Support Personnel (DSP):** • #45 – Date of hire 12/01/2011, completed 12/06/2011. • #47 – Date of hire 5/10/10, completed 6/7/2010. • #48 – Date of hire 12/12/2011, completed 12/19/2011. • #52 – Date of hire 9/30/2010, completed 11/04/2010. • #54 – Date of hire 10/25/2011, completed 10/28/2011. • #56 – Date of hire 1/09/2012, completed 1/12/2012. • #57 – Date of hire 11/29/2011, completed 12/01/2011. • #60 – Date of hire 1/14/2012, completed	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing 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.	1/16/2012. • #65 – Date of hire 8/12/11, completed 8/19/2011. • #68 – Date of hire 1/23/12, completed 1/30/2012. • #69 – Date of hire 12/20/2011, completed 1/02/2012. • #72 – Date of hire 12/27/2011, completed 12/29/2011. • #74 – Date of hire 1/17/2011, completed 3/04/2011. • #77 – Date of hire 12/15/2011, completed 12/19/2011. • #78 – Date of hire 12/02/2011, completed 12/06/2011. • #79 – Date of hire 11/15/2011, completed 11/21/2011. • #80 – Date of hire 11/16/2011, completed 11/21/2011. • #82 – Date of hire 2/01/2012, completed 2/13/2012. • #84 – Date of hire 1/25/2010, completed 10/14/2010. • #86 – Date of hire 1/28/2010, completed 3/18/2010. **Service Coordination Personnel (SC):** • #91 – Date of hire 8/01/2011, completed		

	8/05/2011.		

Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency		
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007** **II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-	Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 9 of 50 Agency Personnel. **Direct Support Personnel (DSP):** • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#44, 50, 51, 71, 72, 75, 76, 81 & 84)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

approved incident reporting procedures in accordance with 7 NMAC 1.13.			

Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Standard Level Deficiency		
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 8 individuals. • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#4)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Tag # 1A37 Individual Specific Training	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (2) **Individual-specific training** for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** **A.** Individuals shall receive services from competent and qualified staff. **B.** Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.	Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 4 of 50 Agency Personnel. Review of personnel records found no evidence of the following: **Direct Support Personnel (DSP):** • Individual Specific Training (#44, 45, 61 & 89)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 1A03 CQI System	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS** **I. Continuous Quality Management System:** Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and	Based on record review and interview, the Agency failed to implement their Continuous Quality Management System as required by standard. The following was not found, not current and or incomplete: • The Agency's Continuous Quality Improvement Plan provided during the on-site survey (February 20-23, 2012) was not dated. No evidence was found indicating when the document had been created or updated. • The Agency's CQI Plan did not contain the following components: ➢ Trends in achievement of individual outcomes in the Individual Service Plans; ➢ Trends in medication and medical incidents leading to adverse health events; ➢ Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; ➢ Quality and completeness documentation; and ➢ community based service providers providing developmental disabilities services must have an incident	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

coordination of healthcare supports at both supervisory and direct support levels; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction. **7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:** **E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system: **(1)** community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements; **(2)** community based service providers providing developmental disabilities services must have a designated incident management coordinator in place; **(4)** community based service providers providing developmental disabilities services must have an incident management committee to address	management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues. **When #95 was asked if the Agency had an Incident Management Quality Improvement System, which included, a process for reviewing alleged, complaints & incident; documentation of internal investigations of alleged violations; reasonable steps taken to prevent further incident and documentation of corrective active, the following was reported:** • #95, stated, "Yes, I review every incident report Direct Care Staff report before sending it out. I do investigations on every internal report. On trending and tracking incidents, I haven't done it yet."		

internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.			

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	*CoP Level Deficiency*		
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;	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of October, November, December, 2011 & February 2012. Based on record review, 8 of 8 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #1 October 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Depakote 500mg (1 time daily) – Blank 10/29 (8 PM) • Depakote 250mg (2 times daily) – Blank 10/29 (8 PM) • Metronidazole (3 times daily) – Blank 10/29 (8 PM) November 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Flonase 0.05% (1 time daily) – Blank 11/1, 2, 3, 4, 6, 7, 8, 9, 10 & 11 (8 AM) December 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Citalopram 20mg (1 time daily) – Blank	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

(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; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug;	12/27 (8 AM) • Desogen (1 time daily) – Blank 12/27 (8 AM) • Lactaid 3,000 Units (1 time daily) – Blank 12/27 (8 AM) • Levothyroxine 75mcg (1 time daily) – Blank 12/27 (8 AM) • Multivitamin (1 time daily) – Blank 12/27 (8 AM) • Cetirizine HCL 10mg (1 time daily) – Blank 12/27 (8 AM) • Abilify 5mg (1 time daily) – Blank 12/18 (8 AM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Abilify 5mg (1 time daily) • Valproic Acid 250mg (1 time daily) February 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Abilify 10mg (1 time daily) • Valproic Acid 250mg (1 time daily) • Metronidazole 500mg (3 times daily) Individual #2 October 2011 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:		

(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.	• Phenobarbital 64.8mg (1 time daily) • Clonidine HCL 0.2mg (1 time daily) • Zyprexa 10mg (1 time daily) • Zyprexa 5mg (1 time daily) November 2011 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Phenobarbital 64.8mg (1 time daily) • Zyprexa 10mg (1 time daily) • Lithium Carbonate 300mg (3 times daily) Medication Administration Records did not contain the route of administration for the following medications: • Lithium Carbonate 300mg (3 times daily) December 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Lithium Carbonate 300mg (3 times daily) – Blank 12/11 (2 PM) • Phenobarbital 32.4mg (1 time daily) – Blank 12/26 (8 PM) Individual #3 October 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Clonazepam 0.5mg (2 times daily) – Blank 10/1 (8 AM)		

	• Benztropine 1mg (2 times daily) – Blank 10/1 (8 AM) & (8 PM) • Haloperidol 5mg (2 times daily) – Blank 10/1 (8 AM) • Divalproex SOD ER 500mg (1 time daily) – Blank 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 ,17, 18, 19, 20, 21, 22, 23 & 31 (8 PM) November 2011 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Propranolol ER 120mg (1 time daily) • Divalproex SOD ER 500mg (1 time daily) December 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Clonazepam 0.5mg (1 time daily) – Blank 12/8 (8 AM) • Risperidone 1mg (2 times daily) – Blank 12/18 (8 AM) • Risperidone 2mg (2 times daily) – Blank 12/25 (8 PM) • Sertraline HCL 100mg (1 time daily) – Blank 12/22 (8AM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Propranolol ER 120mg (1 time daily) • Risperidone 2mg (2 times daily)		

	• Sertraline HCL 100mg (1 time daily) February 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Sertraline HCL 100mg (1 time daily) Individual #4 November 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Body Balance (vitamin) (1 time daily) – Blank 11/19, 24 & 25 (10 AM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Sertraline HCL 100mg (1 time daily) • Metamucil Powder 15ml (1 time daily) Individual #5 October 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Risperidone 3mg (1 time daily) – Blank 10/29, 30 & 31 (8 PM) • Strattera 80mg (1 time daily) – Blank 10/29, 30 & 31 (8 PM) • Depakote EC 500mg (1 time daily) – Blank 10/28, 29, 30 & 31 (8 PM) • Ambien 10mg (1 time daily) – Blank 10/29 & 30 (8 PM)		

	• Trazadone 100mg (1 time daily) – Blank 10/29, 30 & 31 (8 PM) • Propranolol 20mg (2 times daily) – Blank 10/3 (8 AM) 10/29 & 31 (8 PM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Risperidone 3mg (1 time daily) • Risperidone 2mg (1 time daily) • Naltrexone 50mg (1 time daily) November 2011 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Risperidone 3mg (1 time daily) • Risperidone 2mg (1 time daily) December 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Risperidone 3mg (1time daily) – Blank 12/28 (8 AM) • Divalproex SOD ER 250mg (1 time daily) – Blank 12/28 (8 AM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Risperidone 3mg (1 time daily) • Risperidone 2mg (1 time daily) • Naltrexone 50mg (1 time daily)		

	Individual #6 October 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Gemfibrozil 600mg (2 times daily) – Blank 10/22 (8 AM) • Cephalexin 500mg (2 times daily) – Blank 10/20 & 22 (8 AM); 10/26 & 29 (8 PM) December 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Levothyroxine 75mcg (1 time daily) – Blank 12/9 (8 AM) • Methocarbamol 750mg (3 times daily) – Blank 12/22 (8 PM); 12/25 (8 AM) • Depakote EC 500mg (1 time daily) – Blank 12/11 (8 PM) • Benztropine MES 1mg (1 time daily) – Blank 12/9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21 & 25 (8 PM) Individual #7 October 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Zyprexa 10 mg (1 time daily) – Blank 10/25 (12 PM) • Tegretol XR 100mg (3 times daily) – Blank 10/14 & 25 (12 PM) • Clonidine HCL 0.1mg (3 times daily) – Blank		

	10/14 & 25 (12 PM) November 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Zyprexa 10 mg (1 time daily) – Blank 11/28, 29 & 30 (12 PM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Clomipramine 50mg (2 times daily) December 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Anafranil 50 mg (2 times daily) – Blank 12/19 (8 AM) • Vitamin C 500mg (1 time daily) – Blank 12/31 (8 AM) • Tegretol XR 100mg (3 times daily) – Blank 12/16 & 31 (12 PM) • Clonidine HCL 0.1mg (3 times daily) – Blank 12/16, 28 & 31 (12 PM) February 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Tegretol XR 100mg (3 times daily) Individual #8 October 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:		

	• Patanol 0.1% (1 time daily) – Blank 10/29 (8 AM) • Janumet 50-1000mg (2 times daily) – Blank 10/1 (8 AM) • Trihexyphenidyl 5mg (2 times daily) – Blank 10/1 (8 AM) • Ranitidine 150mg (2 times daily) – Blank 10/1 (8 AM) • Fish Oil 1000 (2 times daily) – Blank 10/1 (8 AM) • Lisinopril 5mg (2 times daily) – Blank 10/1 (8 AM) • Levetiracetam 500mg (2 times daily) – Blank 10/1 & 20 (8 AM) • Carbamazepine 200mg (3 times daily) – Blank 10/1 (8 AM) • Fish Oil 1000 (4 times daily) – Blank 10/19 (12 PM) & (4 PM); 10/20 (8 AM); 10/30 & 31 (4 PM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Lorazepam 1mg (1 time daily) • Risperidone 2mg (1 time daily) • Seroquel 50 mg (1 time daily) • Sertraline HCL 100mg (1 time daily) • Risperidone 3mg (1 time daily)		

	• Patanol 0.1% (1 time daily) • Simvastatin 20mg (1 time daily) • Janumet 50-1000mg (2 times daily) • Trihexyphenidyl 5mg (2 times daily) • Ranitidine 150mg (2 times daily) • Lisinopril 5mg (2 times daily) • Levetiracetam 500mg (2 times daily) • Carbamazepine 200mg (3 times daily) November 2011 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Sertraline HCL 100mg (1 time daily) • Levetiracetam 500mg (2 times daily) • Lamotrigine 25mg (2 times daily) December 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Trihexyphenidyl 5mg (2 times daily) – Blank 12/22 (8 PM) • Fish Oil 1000 (4 times daily) – Blank 12/21 (4 PM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Seroquel 100 mg (1 time daily)		

	• Seroquel 200 mg (1 time daily) • Seroquel 50 mg (1 time daily) • Lamotrigine 25mg (1 time daily) • Seroquel 300 mg (1 time daily) • Lamotrigine 100mg (1 time daily) • Patanol 0.1% (1 time daily) • Sertraline HCL 100mg (1 time daily) • Lamictal 25mg (2 times daily) February 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Ranitidine 150mg (2 times daily) • Risperidone 2mg (1 time daily) • Sertraline HCL 100 mg (1 time daily) • Lisinopril 5mg (2 times daily) • Trihexyphenidyl 5.0mg (2 times daily)		

Tag # 1A09.1 Medication Delivery - PRN Medication	Standard Level Deficiency		
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;	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 7 of 8 Individuals. Individual #1 October 2011 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 500mg – PRN – 10/17 (given 1 time) November 2011 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ondansetron 4mg – PRN – 10/28 (given 1 time) • Lorazepam 1mg – PRN – 10/21 & 22 (given 1 time) No evidence of documented Signs/Symptoms were found for the following PRN medication: • Acetaminophen 500mg – PRN – 10/26 & 27 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 500mg – PRN – 10/26 & 27 (given 1 time) December 2011 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Hydroxyzine 50mg – PRN – 12/16, 24, 25 & 27 (given 1 time)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

(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; (iii) Drug product name;	No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Hydroxyzine 50mg – PRN – 12/16, 24, 25, 26 & 27 (given 1 time) Individual #3 October 2011 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Robitussin DM – PRN – 10/10 (given 1 time) • Motrin 200mg – PRN – 10/11 (given 1 time) November 2011 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Robitussin DM – PRN – 11/1 (given 1 time) No evidence of documented Signs/Symptoms were found for the following PRN medication: • Motrin 200mg – PRN – 11/22 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Motrin 200mg – PRN – 11/22 (given 1 time) Medication Administration Records did not contain the circumstance for which the medication is to be used: • Robitussin DM (PRN) • Motrin 200mg (PRN) • Robitussin DM (PRN) Individual #4 October 2011		

(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. **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,	No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Tylenol 500mg – PRN – 10/22 & 28 (given 1 time) November 2011 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Tylenol 500mg – PRN – 11/5, 11, 13 & 15 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Tylenol 500mg – PRN – 11/5, 11, 13 & 15 (given 1 time) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Colace Docusate100mg (PRN) Individual #5 November 2011 Medication Administration Records did not contain the circumstance for which the medication is to be used: • Hydrocortisone Val 0.2% (PRN) Individual #6 October 2011 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Ibuprofen 600mg – PRN – 10/16 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 600mg – PRN – 10/8, 14, 15, 16,		

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**	18, 26 & 31 (given 1 time); 10/13 & 17 (given 2 times) November 2011 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Ibuprofen 600mg – PRN – 11/19 & 27 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 600mg – PRN – 11/19, 21 & 30 (given 1 time) • Pepto-Bismol – PRN – 11/27 (given 1 time) December 2011 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 600mg – PRN – 12/16, 18, 19, 21, 22, 23, 24, 25, 27 & 30 (given 1 time) & 12/6, 12, 13, 14, 15 (given 2 times) Individual #7 November 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A – D 2mg (PRN) December 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A – D 2mg (PRN) Individual #8 October 2011 Medication Administration Records did not contain the exact amount to be used in a 24		

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.).	hour period: • Nitroglycarin 0.4mg (PRN) Medication Administration Records did not contain the circumstance for which the medication is to be used: • Tylenol 500mg (PRN)		

Tag # 1A27.2 Duty to Report - IRs Filed During On-Site / IRs Not Reported by Provider	Standard Level Deficiency		
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	Based on record review, 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 2 of 8 Individuals. During the on-site survey February 20 – 23, 2012 surveyors found evidence of 6 internal agency incident reports, which had not been reported to DHI and/or APS/CYFD, as required by regulation. The following internal incidents were reported as a result of the on-site survey: Individual #1 • Incident date 2/14/2012 (9:45 AM). Type of incident identified was law enforcement involvement. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 2/24/2012 by the Agency. Individual #6 • Incident date 5/26/2011 (6:30 PM). Type of incident identified was abuse. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 2/27/2012 by the Agency. • Incident date 7/15/2011 (11:45 AM). Type of incident identified was emergency services. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 2/27/2012 by the Agency. • Incident date 7/26/2011 (9:20 PM). Type of	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

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. **(2) Division Incident Report Form and Notification by Community Based Service Providers:** The community based service provider shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide. The community based service provider shall ensure all incident report forms alleging abuse, neglect or misappropriation of consumer property submitted by a reporter with direct knowledge of an incident are completed on the division's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The community based service provider shall ensure that the reporter with the most direct knowledge of the incident prepares the incident report form.	incident identified was abuse. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 2/27/2012 by the Agency. • Incident date 9/16/2011 (8:50 PM). Type of incident identified was abuse. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 2/27/2012 by the Agency. • Incident date 10/27/2011 (2:30 PM). Type of incident identified was abuse. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 2/27/2012 by the Agency.		

Tag # 1A28 Incident Mgt. System - Policy & Procedure	Standard Level Deficiency		
7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: **C. Incident Policies:** All community based service providers shall maintain policies and procedures, which describe the community based service provider's immediate response to all reported allegations of incidents involving abuse, neglect, or misappropriation of property; all unexpected deaths or natural/expected deaths, and other reportable incidents required as required in Paragraph (2) of Subsection A of 7.1.13.9 NMAC. **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. **B. Training Curriculum:** The licensed health care facility and community based service provider shall provide all employees and volunteers with a written training curriculum on incident policies and procedures for identification, and timely reporting of abuse, neglect, misappropriation of consumers' property, and where applicable to community based service providers, unexpected deaths or	Based on interview, the Agency failed to establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. **When #95 was asked to explain the Agency's P&P regarding incident management training of staff and timelines involved, the following was reported:** • #95 stated, "16 hours after hire, I don't know how often."	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

other reportable incidents, within thirty (30) days of the employees' initial employment, and by annual review not to exceed twelve (12) month intervals. The training curriculum may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the licensed health care facilities or community based service provider's facility. Training shall be conducted in a language that is understood by the employee and volunteer. **C. Incident Management System Training Curriculum Requirements:** **(1)** The licensed health care facility and community based service provider shall conduct training, or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum that includes but is not limited to: **(a)** an overview of the potential risk of abuse, neglect, misappropriation of consumers' property; **(b)** informational procedures for properly filing the division's incident management report form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and misappropriation of consumers' property. **(d)** specific instructions on how to respond to abuse, neglect, misappropriation of consumers' property; **(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, misappropriation of consumers' property; and **(f)** where applicable to employees of community based service providers, informational procedures for properly filing the division's incident management report form for			

unexpected deaths or other reportable incidents.			

Tag # 1A29 Complaints / Grievances - Acknowledgement	Standard Level Deficiency		
NMAC 7.26.3.6 A These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's complaint or grievance procedure	Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 1 of 8 individuals. • Grievance/Complaint Procedure Acknowledgement (#4)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Tag # 1A31 Client Rights/Human Rights	Standard Level Deficiency		
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] **Long Term Services Division** **Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003** **IV. POLICY STATEMENT -** Human Rights Committees are required for residential service	Based on record review, the Agency failed to ensure the rights of Individuals was not restricted or limited for 4 of 8 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. No documentation was found regarding Human Rights Approval for the following: • Physical Restraint (Removal of sharps) - (Individual #3, 6 & 7) • Psychotropic Medications to control behaviors. (Individual #2)	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

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

Procedure Title: **Medication Assessment and Delivery** **Procedure Eff Date: November 1, 2006** **B. 1. e.** If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).			

Tag # 1A33 Board of Pharmacy - Med Storage	Standard Level Deficiency		
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	Based on observation, the Agency failed to ensure proper storage of medication for 1 of 8 individuals. Observation included: Separate compartments where not kept for each individual living in the home. (Individual #1) During home visit on 2/21/2012 surveyors made the following observations: "When asked to review (Individual #1) PRN medications home staff produced a locked box labeled "Controlled Medication," within this box were the consumer's PRN medication and another roommates controlled medication. Per Agency's Medication Management and Training: "Medication must be separated by person & each person must have a separately locked box for their medication."	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

b. time administered c. name of patient 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 # 6L13 Community Living Healthcare Reqts.	Standard Level Deficiency		
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, whichever 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	Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 2 of 8 individuals receiving Community Living Services. The following was not found, incomplete and/or not current: • **Annual Physical** (#8) • **Dental Exam** ◦ Individual #6 - As indicated by collateral documentation reviewed, exam was completed on 8/8/2011. Referral was made for teeth replacement. No evidence of follow through with referral was found.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by 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). **NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A			

provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.			

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

are not limited to, fire, chemical and/or hazardous waste spills, and flooding.			

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Financial Accountability – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver*.			
Tag # 5I44 Adult Habilitation Reimbursement	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 7 of 7 individuals. Individual #1 December 2011 • The Agency billed 66 units of Adult Habilitation (T2021 U1) from 12/29/2011 through 12/31/2011. Documentation received accounted for 34 units. Individual #2 October 2011 • The Agency billed 32 units of Adult Habilitation (T2021 UJ) from 10/1/2011 through 10/2/2011. Documentation did not contain the required elements on 10/1 & 2. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ No documentation found. • The Agency billed 124 units of Adult Habilitation (T2021 UJ) from 10/18/2011 through 10/24/2011. Documentation received accounted for 100 units. November 2011 • The Agency billed 138 units of Adult Habilitation (T2021 UJ) from 11/1/2011 through 11/7/2011. Documentation received accounted for 136 units.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XVI. REIMBURSEMENT** **A. Billable Unit**. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care. **B. Billable Activities** (1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours. (2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours	December 2011 • The Agency billed 92 units of Adult Habilitation (T2021 UJ) from 12/14/2011 through 12/17/2011. Documentation received accounted for 90 units. • The Agency billed 58 units of Adult Habilitation (T2021 UJ) from 12/27/2011 through 12/30/2011. Documentation received accounted for 22 units. Individual #3 October 2011 • The Agency billed 136 units of Adult Habilitation (T2021 U1/U4) from 10/11/2011 through 10/17/2011. Documentation received accounted for 110 units. November 2011 • The Agency billed 112 units of Adult Habilitation (T2021 U1/U4) from 11/1/2011 through 10/7/2011. Documentation received accounted for 108 units. • The Agency billed 130 units of Adult Habilitation (T2021 U1/U4) from 11/8/2011 through 1/14/2011. Documentation received accounted for 108 units. December 2011 • The Agency billed 72 units of Adult Habilitation (T2021 U1/U4) from 12/1/2011 through 10/6/2011. Documentation received accounted for 62 units. • The Agency billed 114 units of Adult Habilitation (T2021 U1/U4) from 12/21/2011 through 12/26/2011. Documentation received accounted for 98 units.		

	Individual #4 October 2011 • The Agency billed 48 units of Adult Habilitation (T2021 U1/U4) from 10/12/2011 through 10/17/2011. Documentation received accounted for 46 units. November 2011 • The Agency billed 48 units of Adult Habilitation (T2021 U1/U4) from 11/5/2011 through 11/7/2011. Documentation received accounted for 36 units. • The Agency billed 58 units of Adult Habilitation (T2021 U1/U4) from 11/22/2011 through 11/17/2011. Documentation received accounted for 44 units. December 2011 • The Agency billed 40 units of Adult Habilitation (T2021 U1/U4) from 12/2/2011 through 12/4/2011. Documentation received accounted for 24 units. • The Agency billed 64 units of Adult Habilitation (T2021 U1/U4) from 12/13/2011 through 10/19/2011. Documentation received accounted for 49 units. Individual #6 October 2011 • The Agency billed 71 units of Adult Habilitation (T2021 U1/U4) from 10/13/2011 through 10/17/2011. Documentation received accounted for 65 units. • The Agency billed 132 units of Adult Habilitation (T2021 U1/U4) from 10/25/2011 through 10/31/2011. Documentation did not contain the required elements on 11/27. Documentation received accounted for 126		

	units. One or more of the following elements was not met: ➢ Description of what occurred during the encounter or service interval did not meet requirements; December 2011 • The Agency billed 65 units of Adult Habilitation (T2021 U1/U4) from 12/1/2011 through 12/5/2011. Documentation did not contain the required elements on 12/17. Documentation received accounted for 46 units. One or more of the following elements was not met: ➢ Description of what occurred during the encounter or service interval did not meet requirements; • The Agency billed 127 units of Adult Habilitation (T2021 U1/U4) from 12/6/2011 through 12/12/2011. Documentation did not contain the required elements on 12/10 & 12. Documentation received accounted for 107 units. One or more of the following elements was not met: ➢ Description of what occurred during the encounter or service interval did not meet requirements; • The Agency billed 82 units of Adult Habilitation (T2021 U1/U4) from 12/15/2011 through 10/18/2011. Documentation did not contain the required elements on 12/16 & 18. Documentation received accounted for 36 units. One or more of the following elements was not met: ➢ Description of what occurred during the encounter or service interval did not meet requirements; • The Agency billed 56 units of Adult Habilitation (T2021 U1/U4) from 12/29/2011		

	through 12/31/2011. Documentation did not contain the required elements on 12/31. Documentation received accounted for 28 units. One or more of the following elements was not met: ➢ Description of what occurred during the encounter or service interval did not meet requirements; Individual #7 October 2011 • The Agency billed 76 units of Adult Habilitation (T2021 U2) from 10/5/2011 through 10/8/2011. Documentation received accounted for 60 units. • The Agency billed 86 units of Adult Habilitation (T2021 U2) from 10/25/2011 through 10/30/2011. Documentation received accounted for 76 units. Individual #8 October 2011 • The Agency billed 356 units of Adult Habilitation (T2021 U4) from 10/4/2011 through 10/29/2011. Documentation received accounted for 330 units. November 2011 • The Agency billed 262 units of Adult Habilitation (T2021 U4) from 11/1/2011 through 11/14/2011. Documentation received accounted for 228 units.		

Tag # 6L26 Supported Living Reimbursement	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 2 of 8 individuals. Individual #4 December 2011 • The Agency billed 7 units of Supported Living (T2033 U1/UJ from 12/21/2011 through 12/28/2011. Documentation did not contain the required elements on 12/27 & 28. Documentation received accounted for 5 units. One or more of the following elements was not met: ➢ No documentation found. Individual #6 October 2011 • The Agency billed 5 units of Supported Living (T2021 U1/UJ) from 10/7/2011 through 10/11/2011. Documentation did not contain the required elements on 10/8 & 9. Documentation received accounted for 3 units. One or more of the following elements was not met: ➢ No documentation found.	**Provider:** State your Plan of Correction for the findings in this Tag *above* this line. _____ Enter your Quality Assurance/Quality Improvement processes *below* the line.	

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES** A. **Reimbursement** for Supported Living Services (1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year. (2) **Billable Activities** (a) Direct care provided to an individual in the residence any portion of the day. (b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community. (c) Any activities in which direct support staff provides in accordance with the Scope of Services. (3) Non-Billable Activities (a) The Supported Living Services provider shall not bill DD Waiver for Room and Board. (b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services. (c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.			

Date: November 13, 2012

To: Dayna Altom, Administrator
Provider: Wilson Residential Care Services, Inc.
Address: 4623 Greene St. NW, Suite A.
State/Zip: Albuquerque New Mexico, 87114

E-mail Address: wilsonrcs@live.com

Region: Metro
Survey Date: February 20 - 23, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Living Supports (Supported Living) & Inclusion Supports (Adult Habilitation)
Survey Type: Routine

Dear Ms. Altom;

The Division of Health Improvement/Quality Management Bureau has received and reviewed the supporting documents you submitted for your Plan of Correction. However, as of October 31, 2012 all Wilson Residential Clients should have been transitioned to other agencies due to the Department of Health not continuing to contract with your Agency. Any outstanding deficiencies will be referred to the Human Services Department (HSD) for Review.

This concludes the Plan of Correction process with QMB.

Thank you for your cooperation with the Plan of Correction process, for striving to come into compliance with standards and regulations, and for helping to provide for the health, safety and personal growth of the people you serve.

Sincerely,

Crystal Lopez-Beck

Crystal Lopez-Beck
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.13.2.DDW.92351778.5.001.RTN.09.318