Date:	April 5, 2010
To:	Rick Klotz, Director
Provider:	A.W. Holdings of New Mexico, LLC.
Address:	2008 St. Michael's #C21
State/Zip:	Santa Fe, New Mexico 87505
E-mail Address:	rklotz@awsusa.com mgarcia@awsusa.com
Region:	Northeast
Survey Date:	March 22 – 24, 2010
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Community Living (Supported Living) & Community Inclusion (Adult Habilitation & Supported Employment)
Survey Type:	Initial
Team Leader:	Barbara Czinger, MSW, LISW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Cyndie Nielsen, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Angela Pacheco, Developmental Disabilities Specialist, Developmental Disabilities Supports Division.

Dear Mr. Klotz,

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

Quality Management Approval Rating:
The Division of Health Improvement is pleased to issue your new agency a "SUB-STANDARD" rating for non-compliance with DDSD Standards and regulations. As part of your sub-standard rating, your agency is being referred to the Internal Review Committee (IRC) for possible actions.

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

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

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

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

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

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

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

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

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

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

Please call the Team Leader at 505-476-9023, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Barbara Czinger, MSW, LISW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	March 22, 2010
Present:	**A.W. Holdings of New Mexico, LLC.** Rick Klotz, Director Mara Garcia, Incident Management Coordinator **DOH/DHI/QMB** Barbara Czinger, MSW, LISW, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor Cyndie Nielsen, RN, Healthcare Surveyor **DDSD - NE Regional Office** Angela Pacheco, Developmental Disabilities Specialist Developmental Disabilities Supports Division
Exit Conference Date:	March 24, 2010
Present:	**A.W. Holdings of New Mexico, LLC.** Rick Klotz, Director Mara Garcia, Incident Management Coordinator Deirdre Tabler, Human Resources Manager Kathleen Dryer, Director of Nursing Claudia Gabaldon, Program Coordinator Chris Taylor, Program Coordinator Isreal Garcia, Supported Living Manager **DOH/DHI/QMB** Barbara Czinger, MSW, LISW, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor Cyndie Nielsen, RN, Healthcare Surveyor **DDSD - NE Regional Office** Angela Pacheco, Developmental Disabilities Specialist Developmental Disabilities Supports Division
Homes Visited	Number: 6
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 11 4 - Jackson Class Members 7 - Non-Jackson Class Members 9 - Supported Living 8 - Adult Habilitation 1 - Supported Employment
Persons Served Interviewed	Number: 7
Persons Served Observed	Number: 4 (1 consumer was sleeping, 3 consumers were not home at time)
Records Reviewed (Persons Served)	Number: 11
Administrative Files Reviewed	• Billing Records • Medical Records • Incident Management Records • Personnel Files

- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Human Rights Notes and/or Meeting Minutes
- Nursing personnel files
- Evacuation Drills
- Quality Improvement/Quality Assurance Plan

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

Attachment A

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8647.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency ("Responsible Party"), and by WHEN ("Date Due").
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues <u>to prevent</u> <u>the Deficiency from reoccurring</u>, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency's Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to George.Perrault@state.nm.us, by fax (505-222-8661), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been "Approved" or "Denied".
- Whether your POC is "Approved" or "Denied", you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is "Denied" it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- The following Deficiencies must be corrected within the deadlines below (after receipt of your Survey Report):
  - CCHS and EAR: 10 working days
  - Medication errors: 10 working days
  - IMS system/training: 20 working days
  - ISP related documentation: 30 working days
  - DDSD Training 45 working days
- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8647 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.
- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by-case basis.
- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual #s.
- Do not submit original documents, hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Attachment B

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

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

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

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

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

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

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

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

The QMB Approval Rating

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

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

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

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

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

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

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

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

Attachment C

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

Introduction:

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

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

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

The following limitations apply to the IRF process:

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

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

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

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

Administrative Review Process:

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

Regarding IRC Sanctions:

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

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

Agency: **A.W. Holdings of New Mexico, LLC. - Northeast Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living) & Community Inclusion (Adult Habilitation & Supported Employment)
Monitoring Type: Initial Survey
Date of Survey: **March 22 – 24, 2010**

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A08 Agency Case File	**Scope and Severity Rating: A**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual,	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 1 of 11 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • Speech Therapy Plan (#6)		

and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.			

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and	Medication Administration Records (MAR) were reviewed for the months of December 2009, January & February 2010. Based on record review, 4 of 9 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #3 February 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Oxybutyin ER 10mg (1 time daily) – Blank 02/05 (AM) • Abilify 30mg (1 time daily) – Blank 02/05 (AM) • Prenatal Vitamin (1 time daily) – Blank 02/05 (AM) • Folic Acid 1mg (1 time daily) – Blank 02/05 (AM) • Spiriva (1 time daily) – Blank 02/05 (AM) • Cal-Gest Antacid 750mg (2 times daily) – Blank 02/05 (AM) • Ranitidine 150mg (12 times daily) – Blank 02/05 (AM) • Buproprion SR 150mg (1 time daily) – Blank 02/05 (AM) • Systane Artificial Tears (3 times daily) – Blank 02/05 (AM) • Topiramate 50mg (2 times daily) – Blank 02/05 (AM)		

(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff	Individual #4 December 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Portia (1 time daily) Medication Administration Records did not contain the strength of the medication which is to be given: • Portia (1 time daily) January 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Portia (1 time daily) Medication Administration Records did not contain the strength of the medication which is to be given: • Portia (1 time daily) February 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Portia (1 time daily) Medication Administration Records did not contain the strength of the medication which is to be given: • Portia (1 time daily) Individual #9 December 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Ensure Plus (2 times daily) – Blank 12/16 & 23 (PM)		

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.	Physician Orders and Medication Administration Record did not match. Physicians orders dated 9/22/2009 & 12/16/2009 stated, "May crush medications in accordance with pharmacy guidelines." Also, review of the Individual's Meal Time Plan (1/28/2010) indicated medications were to be crushed. The Medication Administration Record failed to indicate what medications were to be crushed for the following: • Lactulose 10GM • Carbamazepine 200mg • Calcium Carbonate Suspension 500mg/5ml • Ranitidine 300mg • Duocosate Sodium 100mg • Loratadine 10mg • Ascorbic Acid 500mg • Alendromate 70mg • Levetiracetam 500mg Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following: • Lactulose 10GM (2 times daily) • Carbamazepine 200mg (3 times daily) • Calcium Carbonate Suspension 500mg/5ml (3 times daily) • Ranitidine 300mg (1 time daily) • Duocosate Sodium 100mg (1 time daily)		

	• Loratadine 10mg (1 time daily) • Ascorbic Acid 500mg (1 time daily) • Alendromate 70mg (1 time weekly) • Levetiracetam 500mg (2 times daily) January 2010 Physician orders and Medication Administration Record did not match. Physicians orders dated 9/22/2009 & 12/16/2009 stated, "May crush medications in accordance with pharmacy guidelines." Also, review of the Individual's Meal Time Plan (1/28/2010) indicated medications were to be crushed. The Medication Administration Record failed to indicate what medications were to be crushed for the following: • Lactulose 10GM • Carbamazepine 200mg • Calcium Carbonate Suspension 500mg/5ml • Ranitidine 300mg • Duocosate Sodium 100mg • Loratadine 10mg • Ascorbic Acid 500mg • Alendromate 70mg • Levetiracetam 500mg Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following: • Lactulose 10GM (2 times daily)		

	• Carbamazepine 200mg (3 times daily) • Calcium Carbonate Suspension 500mg/5ml (3 times daily) • Ranitidine 300mg (1 time daily) • Duocosate Sodium 100mg (1 time daily) • Loratadine 10mg (1 time daily) • Ascorbic Acid 500mg (1 time daily) • Alendromate 70mg (1 time weekly) • Levetiracetam 500mg (2 times daily) February 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Ensure Plus (2 times daily) – Blank 2/17 (AM) Physician Orders and Medication Administration Record did not match. Physicians orders dated 9/22/2009 & 12/16/2009 stated, "May crush medications in accordance with pharmacy guidelines." Also, review of the Individual's Meal Time Plan (1/28/2010) indicated medications were to be crushed. The Medication Administration Record failed to indicate what medications were to be crushed for the following: • Lactulose 10GM • Carbamazepine 200mg • Calcium Carbonate Suspension 500mg/5ml • Ranitidine 300mg • Duocosate Sodium 100mg		

	• Loratadine 10mg • Ascorbic Acid 500mg • Alendromate 70mg • Levetiracetam 500mg Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following: • Lactulose 10GM (2 times daily) • Carbamazepine 200mg (3 times daily) • Calcium Carbonate Suspension 500mg/5ml (3 times daily) • Ranitidine 300mg (1 time daily) • Duocosate Sodium 100mg (1 time daily) • Loratadine 10mg (1 time daily) • Ascorbic Acid 500mg (1 time daily) • Alendromate 70mg (1 time weekly) • Levetiracetam 500mg (2 times daily) Individual #11 December 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Peridex (2 times daily) – Blank 12/2, 3, 15 & 23. (PM) January 2010 Medication Administration Records contained missing entries. No documentation found		

	indicating reason for missing entries: • Peridex (2 times daily) – Blank 1/11, 12, 24, 25, 26 & 27. (PM) February 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Peridex (2 times daily) – Blank 2/1, 3, 7, 8, 9, 10, 21, 22, 23, 24, 25, 26, 27 & 28. (PM)		

Tag # 1A09 Medication Delivery - PRN Medication	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 3 of 9 Individuals. Individual #9 December 2009 Physician orders and Medication Administration Record did not match. Physicians orders dated 9/22/2009 & 12/16/2009 stated, "May crush medications in accordance with pharmacy guidelines." Also, review of the Individual's Meal Time Plan (1/28/2010) indicated medications were to be crushed. The Medication Administration Record failed to indicate what medications were to be crushed for the following: • Tylenol 325mg (PRN) January 2010 Physician orders and Medication Administration Record did not match. Physicians orders dated 9/22/2009 & 12/16/2009 stated, "May crush medications in accordance with pharmacy guidelines." Also, review of the Individual's Meal Time Plan (1/28/2010) indicated medications were to be crushed. The Medication Administration Record failed to indicate what medications were to be crushed for the following: • Tylenol 325mg (PRN) February 2010 Physician orders and Medication Administration Record did not match. Physicians orders dated 9/22/2009 & 12/16/2009 stated, "May crush medications in accordance with pharmacy guidelines." Also, review of the Individual's Meal Time Plan (1/28/2010) indicated medications were to be crushed. The Medication Administration Record failed to indicate what medications were to be crushed for the following:		

(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued	• Tylenol 325mg (PRN) Individual #10 January 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Loratadine 10mg – PRN – 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 25, 26, 28, 29 &30. (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Loratadine 10mg – PRN – January 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 25, 26, 28, 29 & 30. (given1 time) February 2010 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Loratadine 10mg – PRN – 2/1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 18, 19, 20, 23, 24, 25, 26, 27 & 28. (given1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Loratadine 10mg – PRN – 2/1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 18, 19, 20, 23, 24, 25, 26, 27 & 28. (given1 time) Individual #11 February 2010 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Robitussin 10cc – PRN – 2/13, 14, 15, 16, 17, 19, 21, 23 & 24. (given1 time) • Benzonate 200mg - PRN - 2/21, 22, 23 & 28.		

or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period. **Department of Health** **Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006** **F. PRN Medication** 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.	(given 2 times)		

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

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

Tag # 1A12 Reimbursement/Billable Units	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed, which contained the required information for 11 of 11 individuals. Individual #1 December 2009 • The Agency billed 31 units of Supported Living from 12/01/2009 to12/31/2009. Documentation did not contain end time to justify billing. • The Agency billed 508 units of Adult Habilitation from 12/01/2009 to 12/31/2009. Documentation did not contain end time to justify billing. • The Agency billed 4 units of Supported Employment from 12/01/2009 to 12/31/2009. Documentation did not contain end time to justify billing. January 2010 • The Agency billed 31 units of Supported Living from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. • The Agency billed 474 units of Adult Habilitation from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. • The Agency billed 4 units of Supported Employment from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. February 2010 • The Agency billed 28 units of Supported Living from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. • The Agency billed 466 units of Adult Habilitation from 2/01/2010 to 2/28/2010. Documentation		

	did not contain end time to justify billing. • The Agency billed 4 units of Supported Employment from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. Individual #2 December 2009 • The Agency billed 31 units of Supported Living from 12/01/2009 to 12/31/2009. Documentation did not contain end time to justify billing. • The Agency billed 347 units of Adult Habilitation from 12/01/2009 to 12/31/2009. Documentation did not contain end time to justify billing. January 2010 • The Agency billed 31 units of Supported Living from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. • The Agency billed 412 units of Adult Habilitation from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. February 2010 • The Agency billed 28 units of Supported Living from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. • The Agency billed 412 units of Adult Habilitation from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. Individual #3 December 2009 • The Agency billed 31 units of Supported Living from 12/01/2009 to 12/31/2009. Documentation did not contain end time to justify billing. January 2010		

	• The Agency billed 31 units of Supported Living from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. February 2010 • The Agency billed 28 units of Supported Living from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. Individual #4 December 2009 • The Agency billed 31 units of Supported Living from 12/01/2009 to 12/31/2009. Documentation did not contain end time to justify billing. January 2010 • The Agency billed 31 units of Supported Living from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. February 2010 • The Agency billed 28 units of Supported Living from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. Individual #5 December 2009 • The Agency billed 31 units of Supported Living from 12/01/2009 to 12/31/2009. Documentation did not contain end time to justify billing. • The Agency billed 533 units of Adult Habilitation from 12/01/2009 to 12/31/2009. Documentation did not contain end time to justify billing. January 2010 • The Agency billed 31 units of Supported Living from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing.		

	• The Agency billed 504 units of Adult Habilitation from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. February 2010 • The Agency billed 28 units of Supported Living from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. • The Agency billed 480 units of Adult Habilitation from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. Individual #6 January 2010 • The Agency billed 4 units of Adult Habilitation from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. February 2010 • The Agency billed 6 units of Adult Habilitation from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. Individual #7 January 2010 • The Agency billed 181 units of Adult Habilitation from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. February 2010 • The Agency billed 216 units of Adult Habilitation from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. Individual #8 December 2009 • The Agency billed 31 units of Supported Living from 12/01/2009 to 12/31/2009. Documentation did not contain end time to justify billing. January 2010		

	• The Agency billed 31 units of Supported Living from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. February 2010 • The Agency billed 21 units of Supported Living from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. Individual #9 December 2009 • The Agency billed 31 units of Supported Living from 12/01/2009 to12/31/2009. Documentation did not contain end time to justify billing. • The Agency billed 532 units of Adult Habilitation from 12/01/2009 to 12/31/2009. Documentation did not contain end time to justify billing. January 2010 • The Agency billed 31 units of Supported Living from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. • The Agency billed 495 units of Adult Habilitation from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. February 2010 • The Agency billed 28 units of Supported Living from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. • The Agency billed 69 units of Adult Habilitation from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. Individual #10 December 2009 • The Agency billed 31 units of Supported Living from 12/01/2009 to 12/31/2009. Documentation did not contain end time to		

	justify billing. January 2010 • The Agency billed 31 units of Supported Living from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. February 2010 • The Agency billed 28 units of Supported Living from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. Individual #11 December 2009 • The Agency billed 31 units of Supported Living from 12/01/2009 to 12/31/2009. Documentation did not contain end time to justify billing. • The Agency billed 522 units of Adult Habilitation from 12/01/2009 to 12/31/2009. Documentation did not contain end time to justify billing. January 2010 • The Agency billed 31 units of Supported Living from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. • The Agency billed 504 units of Adult Habilitation from 1/01/2010 to 1/31/2010. Documentation did not contain end time to justify billing. February 2010 • The Agency billed 28 units of Supported Living from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing. • The Agency billed 456 units of Adult Habilitation from 2/01/2010 to 2/28/2010. Documentation did not contain end time to justify billing.		

Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. **Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities** (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the	Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 4 of 11 individuals The following were not found, incomplete and/or not current: • **Quarterly Nursing Review of HCP/Crisis Plans:** ° None found for 10/2009 - 12/2009 (#8) • **Health Care Plans** • GERD ° Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. • Hypertension ° Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. • **Crisis Plans** • Oxygen Use ° Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan.		

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

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

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

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 30 of 80 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #13, 23, 61, 63, 70, 75, 86 & 87) • Basic Health/Orientation (DSP #63, 70, 75, 86 & 87) • Person-Centered Planning (1-Day) (DSP #28, 86 & 87) • First Aid (DSP #13, 22, 24, 32, 36, 39, 45, 47, 49, 51, 53, 54, 56, 60, 66, 69 & 87) • CPR (DSP #13, 24, 32, 36, 39, 43, 45, 47, 49, 51, 53, 54, 55, 56, 60, 66, 68, 69 & 87) • Assisting With Medication Delivery (DSP #13, 21, 60, 62, 74, 82, 86 & 87)		

accordance with the specifications described in the individual service plan (ISP) of each individual served. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines. F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements. G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques. H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001. I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services.			

Tag # 1A22 Staff Competence	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **F. Qualifications for Direct Service Personnel:** The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency: (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy	Based on interview, the Agency failed to ensure that training competencies were met for 2 of 9 Direct Service Personnel. **When DSP were asked if they received training on the Individual's Speech Therapy Plan and what the plan covered, the following was reported:** • DSP #85 stated, "I don't know." According to the Individual Specific Training Section of the ISP the Individual requires a Speech Therapy Plan. (Individual #1) **When DSP were asked if they received training on the Individual's Occupational Therapy Plan and what the plan covered, the following was reported:** • DSP #85 stated, "I don't know." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #1) **When DSP were asked if they received training on the Individual's Health Care Plans and what the plan covered, the following was reported:** • DSP #85 stated, "Not that I am aware of." As indicated by the Agency file, the Individual has Health Care Plans for vision, mobility, aspiration, osteoporosis, hypothermia and skin breakdown. (Individual #1) **When DSP were asked if they received training on the Individual's Crisis Plans and what the plan covered, the following was reported:** • DSP #46 stated, "I haven't seen one, but he has epilepsy." As indicated by the Agency file the Individual has Crisis Plans for Seizures.		

Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and (5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support. (6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows: (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff.	(Individual #6) • DSP #85 stated "Yes, an aspiration plan." As indicated by the Agency file, the Individual additionally has a Crisis Plans hypothermia. (Individual #1) **When DSP were asked to describe what to do if there is a medication error, the following was reported:** • DSP #85 stated, "Complete an Incident Report and document in nurses notes. I do not have to document medication errors on the back of Medication Administration Record.' Per Agency policy on medication errors, "Circle the initial on the front of the med sheet and explain on the back of the med sheet what happened." (Individual #1) **When DSP were asked what the individual's Diagnosis were, the following was reported:** • DSP #85 stated, "I don't know." According to the individual's physician's orders dated 01/01/2010 to 01/04/2010 she is diagnosed with Mental Retardation, Hypothermia and Paraplegia. Staff did not discuss the listed diagnosis. (Individual #1)		

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:** **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11** **DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.	Based on record review, the Agency failed to maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 5 of 83 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** • #29 – Date of hire 06/14/2009 • #31 – Date of hire 05/13/2009 • #38 – Date of hire 01/29/2010 • #43 – Date of hire 04/16/2009 • #51 – Date of hire 05/14/2009		

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E		
NMAC 7.1.12.8 **REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED**: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.	Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 59 of 83 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry being completed:** • #18 – Date of hire 10/25/2009 • #20 – Date of hire 05/13/2009 • #67 – Date of hire 05/13/2009 **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** • #12 – Date of hire 05/14/2009. Completed 11/16/2009. • #13 – Date of hire 07/16/2009. Completed 07/17/2009. • #15 – Date of hire 09/02/2009. Completed 03/02/2010. • #16 – Date of hire 05/14/2009. Completed 11/16/2009. • #17 – Date of hire 05/14/2009. Completed 09/16/2009. • #21 – Date of hire 05/14/2009. Completed 11/16/2009. • #22 – Date of hire 05/14/2009. Completed 09/16/2009. • #23 – Date of hire 05/18/2009. Completed 11/16/2009. • #25 – Date of hire 05/13/2009. Completed 07/16/2009. • #26 – Date of hire 05/13/2009. Completed 07/22/2009. • #27 – Date of hire 05/13/2009. Completed 07/22/2009.		

E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1.IV. General Provider Requirements.** **D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.	• #28 – Date of hire 08/27/2009. Completed 11/16/2009. • #29 – Date of hire 06/14/2009. Completed 07/22/2009 • #30 – Date of hire 05/13/2009. Completed 11/16/2009. • #31 – Date of hire 05/13/2009. Completed 07/22/2009. • #32 – Date of hire 06/12/2009. Completed 07/22/2009 • #33 – Date of hire 05/13/2009. Completed 09/16/2009 • #34 – Date of hire 05/13/2009. Completed 07/02/2009 • #35 – Date of hire 05/13/2009. Completed 07/22/2009. • #36 – Date of hire 05/14/2009. Completed 09/16/2009. • #37 – Date of hire 06/14/2009. Completed 07/22/2009. • #38 – Date of hire 01/29/2010. Completed 02/01/2010. • #39 – Date of hire 05/14/2009. Completed 11/16/2009. • #40 – Date of hire 02/16/2010. Completed 02/17/2010. • #41 – Date of hire 05/13/2009. Completed 09/16/2009. • #42 – Date of hire 05/13/2009. Completed 07/27/2009. • #44 – Date of hire 05/13/2009. Completed 07/27/2009. • #46 – Date of hire 05/13/2009. Completed 07/27/2009. • #50 – Date of hire 05/13/2009. Completed 07/27/2009. • #51 – Date of hire 05/14/2009. Completed 09/16/2009. • #54 – Date of hire 05/13/2009. Completed 07/28/2009. • #56 – Date of hire 05/13/2009. Completed		

	07/28/2009. • #57 – Date of hire 05/13/2009. Completed 09/16/2009. • #58 – Date of hire 05/13/2009. Completed 07/28/2009. • #60 – Date of hire 05/13/2009. Completed 07/27/2009. • #63 – Date of hire 10/06/2009. Completed 11/16/2009. • #65 – Date of hire 05/26/2009. Completed 07/28/2009. • #66 – Date of hire 05/13/2009. Completed 07/28/2009. • #68 – Date of hire 05/13/2009. Completed 07/28/2009. • #70 – Date of hire 05/13/2009. Completed 07/28/2009. • #71 – Date of hire 05/14/2009. Completed 07/28/2009. • #72 – Date of hire 05/13/2009. Completed 11/16/2009. • #73 – Date of hire 05/13/2009. Completed 07/28/2009. • #76 – Date of hire 05/13/2009. Completed 07/28/2009. • #77 – Date of hire 06/05/2009. Completed 06/25/2009. • #78 – Date of hire 05/13/2009. Completed 07/28/2009. • #79 – Date of hire 05/13/2009. Completed 09/16/2009. • #80 – Date of hire 05/26/2009. Completed 11/16/2009. • #81 – Date of hire 05/13/2009. Completed 07/28/2009. • #84 – Date of hire 05/13/2009. Completed 06/26/2009. • #85 – Date of hire 05/13/2009. Completed 07/28/2009. • #90 – Date of hire 05/13/2009. Completed 07/28/2009.		

	• #91 – Date of hire 05/13/2009. Completed 06/26/2009. • #92 – Date of hire 05/13/2009. Completed 07/28/2009. • #94 – Date of hire 05/13/2009. Completed 07/22/2009. • #95 – Date of hire 03/17/2010. Completed 03/23/2010.		

Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: E		
7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: **A. Duty To Report:** **(1)** All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. **(2)** All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property**,** unexpected and natural/expected deaths; and other reportable incidents to include: **(a)** an environmental hazardous condition, which creates an immediate threat to life or health; or **(b)** admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider. **(3)** All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. **B. Notification**: **(1) Incident Reporting:** Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.	Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 7 of 16 individuals. Individual #4 • Incident date 8/30/2009. Allegation was Neglect. Incident report was received 9/17/2009. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #9 • Incident date 6/4/2009. Allegation was Neglect. Incident report was received 7/14/2009. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #97 • Incident date 6/10/2009. Allegation was Neglect & Emergency Services. Incident report was received 6/18/2009. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #98 • Incident date 6/10/2009. Allegation was Neglect & Emergency Services. Incident report was received 6/18/2009. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #99 • Incident date 6/29/2009. Allegation was Neglect. Incident report was received 7/2/2009. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." • Incident date 10/14/2009. Allegation was Neglect, Exploitation & Law Enforcement Involvement.		

	Incident report was received 10/21/2009. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #100 • Incident date 8/25/2009. Allegation was Neglect. Incident report was received 8/26/2009. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." • Incident date 9/6/2009. Allegation was Neglect, Exploitation, Emergency Services & Law Enforcement Involvement. Incident report was received 9/10/2009. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #101 • Incident date 8/25/2009. Allegation was Abuse & Neglect. Incident report was received 8/27/2009. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."		

Tag # 1A28 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: D		
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **E. Consumer and Guardian Orientation Packet:** Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 1 of 11 individuals. • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#7)		

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: D		
NMAC 7.26.5.16.C and D **Development of the ISP. Implementation of the ISP.** The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 11 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #7 • None found for 01/01/2010 – 01/31/2010		

Tag # 1A33 Board of Pharmacy - Lic	Scope and Severity Rating: B		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **6. Display of License and Inspection Reports** A. The following are required to be publicly displayed: □ Current Custodial Drug Permit from the NM Board of Pharmacy □ Current registration from the consultant pharmacist □ Current NM Board of Pharmacy Inspection Report	Based on observation, the Agency failed to provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 2 of 6 residences: Individual Residence: • Current NM Board of Pharmacy Inspection report (#3, 9 & 8) (Individuals #3 & 9 live in same residence).		

Tag # 1A36 SC Training	Scope and Severity Rating: B		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training **Requirements for** Direct Support Staff and **Internal Service Coordinators** Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 2 of 3 Service Coordinators. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed: • Promoting Effective Teamwork (SC #91 & 94)		

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.	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 1 of 11 individuals receiving Community Living Services. • **Vision Exam** ° Individual #8 - As indicated by the documentation reviewed, exam was completed on 7/10/2008. Follow-up was to be completed in 12 months. No evidence of follow-up found.		

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).			

Tag # 6L14 Residential Case File	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 7 of 9 Individuals receiving Supported Living Services. The following was not found, incomplete and/or not current: • **Current Emergency & Personal Identification Information** ° Did not contain Pharmacy Information (#1, 2, 4 & 5) • Annual ISP (#9) • Individual Specific Training (Addendum B) (#9) • Speech Therapy Plan (#3 & 8) • Occupational Therapy Plan (#9) • **Crisis Plan** ° Aspiration (#8) ° Gastrointestinal (#8)		

a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings…			

Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services** (1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has: (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence; (b) General-purpose first aid kit; (c) When applicable due to an individual's health status, a blood borne pathogens kit; (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats; (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone; (f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift; (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.	Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 1 of 6 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 (#8)		

Tag # 6L25 (CoP) Residential Reqts. (Physical Environment - Supported Living & Family Living)	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services** (2) Overall each residence shall maintain basic utilities, i.e., gas, power, water, telephone at the residence and shall maintain the physical environment in a safe and comfortable manner for the individuals. (3) Each individual shall have access to all household equipment and cleaning supplies unless precluded by his or her ISP. (4) Living and Dining Areas shall (a) Provide individuals free use of all space with due regard for privacy, personal possessions and individual interests; (b) Maintain areas for the usual functions of daily living, social, and leisure activities in a clean and sanitary condition; and (c) Provide environmental accommodations based on the unique needs of the individual. (5) Kitchen area shall: (a) Possess equipment, utensils, and supplies to properly store, prepare, and serve at least three (3) meals a day; (b) Arrangements will be made, in consultation with the IDT for environmental accommodations and assistive technology devices specific to the needs of the individual(s); and (c) Water temperature is required to be maintained at a safe level to both prevent	Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard, which maintains a physical environment which is safe and comfortable for 1 of 6 Supported Living residences. **Supported Living Requirements:** During the on-site visit (March 23, 2010), surveyors observed the following: Water temperature in the bathroom and the kitchen was set to "High." Water ran excessively hot to the touch.		

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