



**Alfredo Vigil, MD**  
Secretary

DEPARTMENT OF

*Building a Healthy New Mexico!*

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**Jessica Sutin**  
Deputy Secretary

**Karen Armitage, MD**  
Chief Medical Officer

Date: September 1, 2009

To: Patrick Garrity, Executive Director  
Provider: Ability First, LLC  
Address: P.O. Box 30866  
State/Zip: Albuquerque, New Mexico 87190

E-mail Address: ability1st@aol.com

Region: Metro & Southwest  
Survey Date: July 13 - 16, 2009  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Community Living (Independent Living & Family Living) & Community Inclusion (Community Access)  
Survey Type: Routine  
Team Leader: Crystal Lopez-Beck, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Team Members: Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Barbara Czinger, MSW, LISW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Florie Alire, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Garrity.,

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/Quality Management Bureau is granting your agency a "SUB-STANDARD" certification for significant non-compliance with DDS Standards and regulations; additionally your agency is being referred to the Internal Review Committee for consideration of remedies and possible sanctions.

**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 900 Albuquerque, NM 87108
2. Developmental Disabilities Supports Division Regional Office for region of service surveyed.

*"Assuring safety and quality of care in New Mexico's health facilities and community-based programs."*

**David Rodriguez, Division Director • Division of Health Improvement**

Division of Health Improvement • Quality Management Bureau • 5301 Central Ave NE • Suite 900 • Albuquerque, New Mexico 87108  
(505) 222-8623 • FAX: (505) 841-5815

DHI Quality Review Survey Report – Ability First, LLC - Metro & SW Region - July 13 - 16, 2009

Report #: Q10.01.24883310.METRO & SW.001.RTN.01

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 #900  
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 505-222-6625, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

*Crystal Beck-Lopez, BA*

Crystal Lopez-Beck, BA  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: July 13, 2009

Present: **Ability First**  
Patrick Garrity, Executive Director

**DOH/DHI/QMB**

Crystal Lopez-Beck, BA, Team Lead/Healthcare Surveyor  
Barbara Czinger, MSW, LISW, Healthcare Surveyor  
Florie Alire, RN, Healthcare Surveyor  
Nadine Romero, LBSW, Healthcare Surveyor

Exit Conference Date: July 16, 2009

Present: **Ability First**  
Patrick Garrity, Executive Director  
Zuly Abrego, Service Coordinator  
Marcie McClafin, Staff Coordinator  
Gilbert Chavez, Service Coordinator

**DOH/DHI/QMB**

Crystal Lopez-Beck, BA, Team Lead/Healthcare Surveyor  
Nadine Romero, LBSW, Healthcare Surveyor

Homes Visited Number: 12

Administrative Locations Visited Number: 1

Total Sample Size Number: 15  
0 - Jackson Class Members  
15 - Non-Jackson Class Members  
12 - Family Living  
3 - Independent Living  
1 - Community Access

Persons Served Interviewed Number: 12

Persons Served Observed Number: 3 (One individual was unavailable during the onsite week of July 13, 2009, One individual was unable to answer interview questions, and the other individual did not want to participate in the interview)

Records Reviewed (Persons Served) Number: 15

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

## 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 505-222-8624.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency (“Responsible Party”), and by WHEN (“Date Due”).
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues to prevent the Deficiency from reoccurring, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency’s Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to George.Perrault@state.nm.us, by fax (505-841-5815), 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 505-222-8624 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.

**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.

## **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:** Ability First, LLC – Metro & Southwest Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Living (Family Living & Independent Living) & Community Inclusion (Community Access)  
**Monitoring Type:** Routine  
**Date of Survey:** July 13 - 16, 2009

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<b>Tag # 1A03 CQI System</b>	<b>Scope and Severity Rating: C</b>		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 <b>CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS</b> <b>I. Continuous Quality Management System:</b> Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both	Based on record review, the Agency failed to update and implement their Continuous Quality Management System on an annual basis.  The Agency's Continuous Quality Improvement Plan provided during the on-site survey (July 13, 2009) was not dated. No evidence was found indicating when the document had been created or updated.		

- supervisory and direct support levels;
- (6) Quality and completeness documentation; and
- (7) Trends in individual and guardian satisfaction.

**7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:**

**E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system:

- (1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;
- (2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;
- (4) community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.

Tag # 1A05 (CoP) General Requirements	Scope and Severity Rating: F		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>A. General Requirements:</b></p> <p>(2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDS policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.</p>	<p>Based on record review, the Agency failed to review and update its written policies and procedures every three years or as needed.</p> <p>The following policies and procedures provided during the on-site survey (July 13, 2009) showed no evidence of being reviewed every three years or being updated as needed:</p> <ul style="list-style-type: none"> <li>• “Grievance Policy” – Last reviewed and/or revised – unknown, not dated.</li> </ul>		

Tag # 1A06 Provider Agency Policy and Procedure Requirements	Scope and Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1. II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>B. Provider Agency Policy and Procedure Requirements:</b> All Provider Agencies, in addition to requirements under each specific service standard shall at a minimum develop, implement and maintain, at the designated Provider Agency main office, documentation of policies and procedures for the following:</p> <ol style="list-style-type: none"> <li>(1) Coordination of Provider Agency staff serving individuals within the program which delineates the specific roles of agency staff, including expectations for coordination with interdisciplinary team members who do not work for the provider agency;</li> <li>(2) Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated; and</li> <li>(3) Agency protocols for disaster planning and emergency preparedness.</li> </ol>	<p>Based on interview, the Agency failed to ensure Agency Personnel were aware of the Agency's On-Call Policy &amp; Procedures for 1 of 14 Agency Personnel.</p> <p>When DSP were asked if the agency had an on-call procedure, the following was reported:</p> <ul style="list-style-type: none"> <li>• DSP #14 stated, "I don't know." (Individuals #3 &amp; 11)</li> </ul>		

Tag # 1A08 Agency Case File	Scope and Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>D. Provider Agency Case File for the Individual:</b> 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:</p> <ol style="list-style-type: none"> <li>(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;</li> <li>(2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);</li> <li>(3) Progress notes and other service delivery documentation;</li> <li>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</li> <li>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the</li> </ol>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 1 of 15 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> <li>• Annual ISP (#12)</li> <li>• ISP Signature Page (#12)</li> <li>• Individual Specific Training Section (ISP) (#12)</li> </ul>		

<p>developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(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</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <ul style="list-style-type: none"> <li>(a) Complete file for the past 12 months;</li> <li>(b) ISP and quarterly reports from the current and prior ISP year;</li> <li>(c) Intake information from original admission to services; and</li> <li>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</li> </ul>			
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Tag # 1A09 Medication Delivery (MAR)	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>E. Medication Delivery:</b> Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <p>(a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;</p> <p>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</p> <p>(c) Initials of the individual administering or assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the</p>	<p>Medication Administration Records (MAR) were reviewed for the months of March, April &amp; May 2009.</p> <p>Based on record review, 6 of 10 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #7 During on-site survey Medication Administration Records were requested for months of March, April and May 2009. As of July 17, 2009, Medication Administration Records had not been provided.</p> <p>Individual #8 May 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Omeprazole 40mg (2 times daily)</li> <li>• Iron Sulfate 425mg (3 times daily)</li> <li>• Docusate 100mg (2 times daily)</li> </ul> <p>Individual #9 During on-site survey Medication Administration Records were requested for months of April and May 2009. As of July 17, 2009, Medication Administration Records had not been provided.</p> <p>March 2009 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> <li>• Aspirin 81mg (1 time daily)</li> <li>• Vitamin B12 100mcg (1 time daily)</li> <li>• Multivitamin (1 time daily)</li> </ul>	

<p>use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p><b>NMAC 16.19.11.8 MINIMUM STANDARDS:</b>  <b>A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</b></p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, <b>including over-the-counter medications.</b> This documentation shall include:</p> <ul style="list-style-type: none"> <li>(i) Name of resident;</li> <li>(ii) Date given;</li> <li>(iii) Drug product name;</li> <li>(iv) Dosage and form;</li> <li>(v) Strength of drug;</li> <li>(vi) Route of administration;</li> <li>(vii) How often medication is to be taken;</li> <li>(viii) Time taken and staff initials;</li> <li>(ix) Dates when the medication is discontinued or changed;</li> <li>(x) The name and initials of all staff administering medications.</li> </ul>	<ul style="list-style-type: none"> <li>• Synthroid 25mcg (1 time daily)</li> <li>• Fosamax 70mg (1 time weekly)</li> <li>• Metrogel Topical 1% Gel (1 time daily)</li> <li>• Calcium w/ D 600mg (3 times daily)</li> <li>• Senokot-S (2 times daily)</li> </ul> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Loratadine 10mg (1 time daily)</li> <li>• Fosamax 70mg (1 time weekly)</li> <li>• Lasix 40mg (1 time daily)</li> <li>• Senna (1 time daily)</li> </ul> <p>Individual #10  During on-site survey Medication Administration Records were requested for months of May 2009. As of July 17, 2009, Medication Administration Records had not been provided.</p> <p>March 2009  Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> <li>• Fatical 50mg (2 times daily)</li> <li>• Debrox Drops (1 time daily)</li> <li>• O-Mega 3 200ml (2 times daily)</li> <li>• Liquid Multi 437ml (2 times daily)</li> </ul> <p>April 2009  Medication Administration Records contain the</p>		
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**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.

following medications. No Physician's Orders were found for the following medications:

- Fatical 50mg (2 times daily)
- Debrox Drops (1 time daily)
- O-Mega 3 200ml (2 times daily)
- Liquid Multi 437mLl(2 times daily)

Individual #13

April 2009

As indicated by the Medication Administration Records the individual is to take Prozac Liquid 2.5ml (1 time daily). According to the Physician's Orders, Prozac liquid 20mg/5ml is to be taken 1 time daily. Medication Administration Record & Physician's Orders do not match.

Individual #14

March 2009

Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:

- Pantoprazole 40mg (1 time daily)

April 2009

Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:

- Pantoprazole 40mg (1 time daily)

May 2009

Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:

- Pantoprazole 40mg (1 time daily)

Tag # 1A09 Medication Delivery - PRN	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>E. Medication Delivery:</b> Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <ol style="list-style-type: none"> <li>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;</li> <li>Prescribed dosage, frequency and method/route of administration, times and dates of administration;</li> <li>Initials of the individual administering or assisting with the medication;</li> <li>Explanation of any medication irregularity;</li> <li>Documentation of any allergic reaction or adverse medication effect; and</li> <li>For PRN medication, an explanation for the</li> </ol>	<p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 4 of 10 Individuals.</p> <p>Individual #2 March 2009</p> <p>Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> <li>Lasix 20mg (PRN)</li> </ul> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> <li>Zestril 2.5mg (PRN)</li> <li>Dilaudid 2mg to 4mg (PRN)</li> </ul> <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>Zestril 2.5mg – PRN – 3/18, 22, 24, 28 &amp; 30 (given 1 time daily)</li> <li>Dilaudid 2mg – 4mg – PRN – 03/3, 4, 6, 8, 10, 12, 16, 25, 30 &amp; 31 (given 1 time daily); 3/1, 5, 9, 26, 27 &amp; 29 (given 2 times daily) &amp; 03/28 (given 4 times daily)</li> </ul> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>Zestril 2.5mg – PRN – 03/18, 22, 24, 28 &amp; 30 (given 1 time daily)</li> <li>Dilaudid 2mg – 4mg – 03/3, 4, 6, 8, 10, 12, 16, 25, 30 &amp; 31 (given 1 time daily); 3/1, 5, 9, 26, 27 &amp; 29 (given 2 times daily) &amp; 03/28 (given 4 times daily)</li> </ul>	

<p>use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p><b>Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006</b></p> <p><b>F. PRN Medication</b></p> <p>3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to 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</p>	<p>April 2009</p> <p>Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> <li>• Lasix 20mg (PRN)</li> </ul> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> <li>• Lasix 20mg (PRN)</li> <li>• Promethazine 25mg (PRN)</li> <li>• Dilaudid 2mg - 4mg (PRN)</li> <li>• Zestril 2.5mg (PRN)</li> </ul> <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Dilaudid 2mg - 4mg – PRN – 04/1, 2, 7, 12, 13, 19 &amp; 29 (given 1 time daily); 04/17, 25, 28 &amp; 30 (given 2 times daily); 04/3, 5, 6 &amp; 20 (given 3 times daily); 04/18 (given 4 times daily) &amp; 04/24 (given 6 times daily)</li> <li>• Lasix 20mg – PRN – 04/20, 21, 24, 27 &amp; 30 (given 1 time daily)</li> <li>• Promethazine 25mg – PRN – 04/18 &amp; 30 (given 1 time daily)</li> </ul> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Dilaudid 2mg - 4mg – PRN – 04/1, 2, 7, 12, 13, 19 &amp; 29 (given 1 time daily); 04/17, 25, 28 &amp; 30 (given 2 times daily); 04/3, 5, 6 &amp; 20 (given 3 times daily); 04/18 (given 4 times daily) &amp; 04/24 (given 6 times daily)</li> <li>• Lasix 20mg – PRN – 04/20, 21, 24, 27 &amp; 30</li> </ul>		
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<p>consanguinity to the individual.</p> <p><b>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</b></p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, <b>including over-the-counter medications</b>. This documentation shall include:</p> <ul style="list-style-type: none"> <li>(i) Name of resident;</li> <li>(ii) Date given;</li> <li>(iii) Drug product name;</li> <li>(iv) Dosage and form;</li> <li>(v) Strength of drug;</li> <li>(vi) Route of administration;</li> <li>(vii) How often medication is to be taken;</li> <li>(viii) Time taken and staff initials;</li> <li>(ix) Dates when the medication is discontinued or changed;</li> <li>(x) The name and initials of all staff administering medications.</li> </ul> <p><b>Model Custodial Procedure Manual D. Administration of Drugs</b></p> <p>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.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> <li>➤ symptoms that indicate the use of the medication,</li> <li>➤ exact dosage to be used, and</li> <li>➤ the exact amount to be used in a 24 hour period.</li> </ul>	<p>(given 1 time daily)</p> <ul style="list-style-type: none"> <li>•Promethazine 25mg – PRN – 04/18 &amp; 30 (given 1 time daily)</li> <li>•Zestril 2.5mg – PRN – 04/5, 6, 10, 11, 14, 19 &amp; 28 (given 1 time daily)</li> </ul> <p>May 2009 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> <li>• Lasix 20mg (PRN)</li> </ul> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> <li>•Lasix 20mg (PRN)</li> <li>•Promethazine 25mg (PRN)</li> <li>•Dilaudid 2mg - 4mg (PRN)</li> <li>•Zestril 2.5mg (PRN)</li> </ul> <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>•Lasix 20mg – PRN – 05/5, 7, 11, 14, 27 &amp; 29 (given 1 time daily)</li> </ul> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>•Dilaudid 2mg-4mg– PRN – 5/1, 9, 10, 11, 13, 19, 23, 24 &amp; 29 (given 1 time daily); 5/2, 3, 7, 25 &amp; 26, (given 2 times daily) &amp; 5/5 &amp; 27 (given 3 times daily)</li> <li>•Lasix 20mg – PRN – 5/5, 7, 11, 14, 27 &amp; 29 (given 1 time daily)</li> </ul>	
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	<ul style="list-style-type: none"> <li>•Promethazine 25mg – PRN – 5/5, 24 &amp; 27 (given 1 time daily)</li> <li>•Zestril 2.5mg – PRN – 5/4, 17, 18, 23, 24 &amp; 28 (given 1 time daily); 5/16 (given 2 times daily) &amp; 5/11 (given 3 times daily)</li> </ul> <p>Individual #6 April 2009 No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>•Omeprazole 20mg – PRN – 4/4, 5 &amp; 6 (given 2 times daily); 4/7 - 23 (given 1 time daily)</li> </ul> <p>Individual #8 March 2009 Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:</p> <ul style="list-style-type: none"> <li>•Hydrocodone 500mg (PRN)</li> </ul> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>•Hydrocodone 500mg – PRN – 3/13 - 27 (given 2 time(s) daily)</li> </ul> <p>Individual #13 March 2009 As indicated by the Medication Administration Records the individual is to take Lorazepam 0.50 ml (as needed). According to the Physician’s Orders, Lorazepam ½ ml is to be taken 2 times daily as needed. Medication Administration Record &amp; Physician’s Orders do not match.</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>•Lorazepam 0.50ml – 2 times daily PRN – 3/12- 21 &amp; 23 - 31 (given 1 time daily)</li> </ul>		
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	<p>April 2009</p> <p>As indicated by the Medication Administration Records the individual is to take Lorazepam 0.5 ml (0.25ml) (2 times daily as needed). According to the Physician's Orders, Lorazepam ½ ml is to be taken 2 times daily as needed. Medication Administration Record &amp; Physician's Orders do not match.</p> <p>As indicated by the Physicians Orders, the individual is to take Lorazepam ½ ml (2 times daily as needed). According to the Medication Administration Record, Lorazepam 0.25ml was given 2 times daily. Medication was not given as indicated by the Physician's Orders on the following days:</p> <ul style="list-style-type: none"> <li>• April 15 - 20 &amp; 24 - 30.</li> </ul> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Lorazepam 0.50ml – 2 times daily PRN – 4/1 - 14 &amp; 23. (give 1 time daily) &amp; 4/21 &amp; 22 (given 2 times daily)</li> <li>• Lorazepam 0.25ml – as documented on the MAR – 4/15, 16, 17, 18, 19, 20, 24, 25, 26, 27, 28, 29 &amp; 30 (given 2 times daily)</li> </ul> <p>May 2009</p> <p>As indicated by the Medication Administration Records the individual is to take Lorazepam 0.50 ml (2 times daily as needed) or 0.25ml-0.18ml (4 times daily as needed). According to the Physician's Orders, Lorazepam ½ ml is to be taken 2 times daily as needed. Medication Administration Record &amp; Physician's Orders do not match.</p> <p>As indicated by the Physicians Orders, the individual is to take Lorazepam ½ ml (2 times daily as needed). According to the Medication</p>		
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	<p>Administration Record, Lorazepam 0.25ml or 0.18ml was given 4 times daily. Medication was not given as indicated by the Physician's Orders on the following days:</p> <ul style="list-style-type: none"><li>• May 1 - 31.</li></ul>		
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Tag # 1A11 (CoP) Transportation Training	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>G. Transportation:</b> Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety". The policy and procedures must address at least the following topics:</p> <ol style="list-style-type: none"> <li>(1) Drivers' requirements,</li> <li>(2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions,</li> <li>(3) Vehicle maintenance and safety inspections,</li> <li>(4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures,</li> <li>(5) Emergency Plans, including vehicle evacuation techniques,</li> <li>(6) Documentation, and</li> <li>(7) Accident Procedures.</li> </ol> <p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy</b> Training Requirements for Direct Service Agency</p>	<p>Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 29 of 50 Direct Service Personnel.</p> <p>No documented evidence was found of the following required training:</p> <ul style="list-style-type: none"> <li>• Transportation (DSP #40, 42, 43, 44, 45, 46, 49, 50, 51, 52, 53, 57, 58, 59, 60, 61, 62, 64, 66, 71, 72, 80, 81, 83, 86, 87, 88 &amp; 89)</li> </ul> <p>When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported:</p> <p>DSP #41 stated, "I don't know."</p> <p>DSP #46 stated, "No."</p>		

Staff Policy **Eff Date:** March 1, 2007

**II. POLICY STATEMENTS:**

I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:

1. Operating a fire extinguisher
2. Proper lifting procedures
3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat)
4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)
5. Operating wheelchair lifts (if applicable to the staff's role)
6. Wheelchair tie-down procedures (if applicable to the staff's role)
7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)

Tag # 1A12 Reimbursement/Billable Units	Scope and Severity Rating: C		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>A. General:</b> All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</p> <p><b>B. Billable Units:</b> The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <ol style="list-style-type: none"> <li>(1) Date, start and end time of each service encounter or other billable service interval;</li> <li>(2) A description of what occurred during the encounter or service interval; and</li> <li>(3) The signature or authenticated name of staff providing the service.</li> </ol> <p><b>MAD-MR: 03-59 Eff 1/1/2004</b></p> <p><b>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b></p> <p>Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p>	<p>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 14 of 15 individuals.</p> <p>Individual #1 March 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 03/01/2009 through 03/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>April 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 04/01/2009 through 04/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>May 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 29 units of Family Living from 05/01/2009 through 05/29/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>Individual #2 March 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 03/01/2009 through 03/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one</li> </ul>		

	<p>signature for each set of progress notes.</p> <p>April 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 28 units of Family Living from 04/01/2009 through 04/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>May 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 29 units of Family Living from 05/01/2009 through 05/29/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>Individual #3</p> <p>March 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 1 unit of Independent Living the month of March 2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for the following dates: 3/04, 02, 05, 18 &amp; 23. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>April 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 1 unit of Independent Living the month of April 2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for the following dates: 4/01, 15, 16 &amp; 20. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>May 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 1 unit of Independent Living the month of May 2009. Documentation did not</li> </ul>		
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	<p>contain a signature/authenticated name of the staff providing the service to justify billing for the following dates: 05/04, 20, 22 &amp; 27. Documentation only contained one signature for each set of progress notes.</p> <ul style="list-style-type: none"> <li>• The Agency billed 1 unit of Independent Living the month of May 2009. Documentation did not contain start and end time to justify billing for the following dates: 05/11.</li> </ul> <p>Individual #4 March 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 1 unit of Independent Living for the month of March 2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for the following dates: 3/03, 06, 11, 18, 20, 26 &amp; 27. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>April 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 1 unit of Independent Living for the month of April 2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for the following dates: 4/02, 07, 10, 21 &amp; 28. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>May 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 1 unit of Independent Living for the month of May 2009. Documentation did not contain a signature/authenticated name of the staff providing the service for each entry to justify billing for the following dates: 5/01, 13, 14, 19, 27, 28, 29 &amp; 30. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>Individual #5 March 2009</p>		
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	<ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 03/01/2009 through 03/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>April 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 04/01/2009 through 04/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>May 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 29 units of Family Living from 05/01/2009 through 05/29/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>Individual #6 March 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 03/01/2009 through 03/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>April 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 04/01/2009 through 04/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each</li> </ul>		
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	<p>unit billed. Documentation only contained one signature for each set of progress notes.</p> <p>May 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 29 units of Family Living from 05/01/2009 through 05/29/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>Individual #7 March 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 28 units of Family Living from 03/01/2009 through 03/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>April 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 28 units of Family Living from 04/01/2009 through 04/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>May 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 29 units of Family Living from 05/01/2009 through 05/29/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>Individual #8 March 2009</p>		
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	<ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 03/01/2009 through 03/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>April 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 04/01/2009 through 04/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>May 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 29 units of Family Living from 05/01/2009 through 05/29/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>Individual #10 March 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 03/01/2009 through 03/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>April 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 04/01/2009 through 04/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each</li> </ul>		
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	<p>unit billed. Documentation only contained one signature for each set of progress notes.</p> <p>May 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 29 units of Family Living from 05/01/2009 through 05/29/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>Individual #11</p> <p>March 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 1 unit of Independent Living for the month of March 2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for the following dates: 03/04, 05, 11, 18, 20, 24 &amp; 26, Documentation only contained one signature for each set of progress notes.</li> <li>The Agency billed 1 unit of Independent Living the month of March 2009. Documentation did not contain start and end time to justify billing for the following dates: 03/11, 12, 25, 26 &amp; 27.</li> </ul> <p>April 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 1 unit of Independent Living for the month of April 2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for the following dates: 04/01, 08, 09, 15, 18, 22, 23, 25 &amp; 29. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>May 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 1 unit of Independent Living for the month of May 2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for the following dates: 05/01, 05, 11, 14, 19, 20 &amp;</li> </ul>		
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	<p>27. Documentation only contained one signature for each set of progress notes.</p> <ul style="list-style-type: none"> <li>• The Agency billed 1 unit of Independent Living the month of May 2009. Documentation did not contain start and end time to justify billing for the following dates: 05/13, 14 &amp; 15.</li> </ul> <p>Individual #12 March 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 03/01/2009 through 03/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>April 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 04/01/2009 through 04/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>May 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 29 units of Family Living from 05/01/2009 through 05/29/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>Individual #13 March 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 03/01/2009 through 03/28/2009. Documentation did not contain a signature/authenticated name of the staff</li> </ul>		
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	<p>providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</p> <p>April 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 28 units of Family Living from 04/01/2009 through 04/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>May 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 29 units of Family Living from 05/01/2009 through 05/29/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>Individual #14</p> <p>March 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 28 units of Family Living from 03/01/2009 through 03/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>April 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 28 units of Family Living from 04/01/2009 through 04/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>May 2009</p>		
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	<ul style="list-style-type: none"> <li>• The Agency billed 29 units of Family Living from 05/01/2009 through 05/29/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>Individual #15 March 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 03/01/2009 through 03/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>April 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Family Living from 04/01/2009 through 04/28/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul> <p>May 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 29 units of Family Living from 05/01/2009 through 05/29/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation only contained one signature for each set of progress notes.</li> </ul>		
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Tag # 1A15 Nurse Availability	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:</b> Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p><b>NEW MEXICO NURSING PRACTICE ACT CHAPTER 61, ARTICLE 3</b></p> <p>I. "licensed practical nursing" means the practice of a directed scope of nursing requiring basic knowledge of the biological, physical, social and behavioral sciences and nursing procedures, which practice is at the direction of a registered nurse, physician or dentist licensed to practice in this state. This practice includes but is not limited to:</p> <p>(1) contributing to the assessment of the health status of individuals, families and communities;</p> <p>(2) participating in the development and modification of the plan of care;</p> <p>(3) implementing appropriate aspects of the plan of care commensurate with education and verified competence;</p> <p>(4) collaborating with other health care professionals in the management of health care; and</p> <p>(5) participating in the evaluation of responses to interventions;</p>	<p>Based on interview, the Agency failed to ensure nursing services were available as needed for 3 of 15 individuals.</p> <p>When DSP were asked about the availability of their agency nurse, the following was reported:</p> <ul style="list-style-type: none"> <li>• DSP #47 stated, "I'm not sure if there is a nurse available."</li> <li>• DSP #48 stated, "I don't know if there is a nurse available."</li> <li>• DSP #51 stated, "We meet with her annually but I don't know how to reach her other than that."</li> </ul>		

Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:</b> Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p><b>(1) Documentation of nursing assessment activities</b></p> <p>(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:</p> <ul style="list-style-type: none"> <li>(i) Community living services provider agency;</li> <li>(ii) Private duty nursing provider agency;</li> <li>(iii) Adult habilitation provider agency;</li> <li>(iv) Community access provider agency; and</li> <li>(v) Supported employment provider agency.</li> </ul> <p>(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</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 3 of 15 individual</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• Health Assessment Tool (#12)</li> <li>• Medication Administration Assessment Tool (#12)</li> <li>• <b>Quarterly Nursing Review of HCP/Crisis Plans:</b> <ul style="list-style-type: none"> <li>◦ 07/2008 - 06/2009 (#9)</li> </ul> </li> <li>• <b>Special Health Care Needs:</b></li> <li>• <b>Crisis Plans</b> <ul style="list-style-type: none"> <li>• Seizures <ul style="list-style-type: none"> <li>◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> <li>• Heart Condition <ul style="list-style-type: none"> <li>◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> <li>• Allergies <ul style="list-style-type: none"> <li>◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> </ul> </li> </ul>		

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 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

<p>intervention plan must be written by the nurse or other appropriately designated healthcare professional.</p> <p>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.</p> <p>(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.</p> <p>(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.</p> <p><b>(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):</b></p> <p>(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.</p> <p>(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.</p> <p>(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</p>			
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<p>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.</p> <p>(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.</p> <p>(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.</p> <p>(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.</p> <p>(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.</p> <p>(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.</p> <p><b>(4) General Nursing Documentation</b></p> <p>(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.</p> <p>(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.</p>			
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Tag # 1A20 DSP Training Documents	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p><b>C. Orientation and Training Requirements:</b> Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <ol style="list-style-type: none"> <li>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</li> <li>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</li> </ol>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 2 of 50 Direct Service Personnel.</p> <p>Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> <li>• Person-Centered Planning (1-Day) (DSP #61)</li> <li>• CPR (DSP #56)</li> </ul>		

Tag # 1A22 Staff Competence	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p><b>F. Qualifications for Direct Service Personnel:</b> The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</p> <p>(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;</p> <p>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</p> <p>(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;</p> <p>(4) Direct service personnel shall meet the qualifications specified by DDS in the Policy</p>	<p>Based on interview, the Agency failed to ensure that training competencies were met for 5 of 14 Direct Service Personnel.</p> <p>When DSP were asked if the individual had any crisis plans for medical or behavior issues, the following was reported:</p> <ul style="list-style-type: none"> <li>DSP #40 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Crisis Plan). (Individual #40)</li> </ul> <p>When DSP were asked if they had received training on the individual's Health Care Plans and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> <li>DSP #48 stated, "No, I don't believe there are any health care plans written by the Ability First agency nurse." According to ISP the individual has a HAT score of 4 and the Individual Specific Training section of the ISP indicates there are HCPs. (Individual #9)</li> </ul> <p>When DSP were asked if they received training on the Individual's Crisis Plans and what the plan covered,, the following was reported:</p> <ul style="list-style-type: none"> <li>DSP #48 stated, "No, I don't think there are any crisis plans written by the Ability First agency nurse." As indicated by the Agency file, the Individual has Crisis Plans for cardiac condition, potential for deterioration in health and for her CPAP machine. (Individual #9)</li> </ul> <p>When DSP were asked, what they are supposed to do if there is a medication error, the following was reported:</p> <ul style="list-style-type: none"> <li>DSP #40 stated, "I would put the medication in a bag and throw it in the trash. Then I would document on the MAR." (Individual #1)</li> </ul>	

<p>Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and</p> <p>(5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support.</p> <p>(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:</p> <p>(a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services;</p> <p>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</p> <p>(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p>	<ul style="list-style-type: none"> <li>• DSP #53 stated, "I would document on the MAR. Bag it and throw it away or crush it and flush it down the toilet." (Individual #15)</li> </ul> <p>When DSP were asked, what are the steps did they need to take before assisting an individual with PRN medication, the following was reported:</p> <ul style="list-style-type: none"> <li>• DSP #47 stated, "I just give the medication, I do not call the nurse for PRN medications." According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP) (Individual #8)</li> <li>• DSP #48 stated, "I just give the medication, I do not call the nurse for PRN medications." According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP) (Individual #9)</li> </ul> <p>When DSP were asked to describe the signs and symptoms of an allergic reaction to food, the following was reported:</p> <ul style="list-style-type: none"> <li>• DSP #49 stated, "Itching." (DSP was unable to give any other signs or symptoms of an allergic reaction to food. (Individual #10)</li> </ul> <p>When DSP were asked to describe the signs and symptoms of an adverse reaction to a medication,</p>		
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	<p>the following was reported:</p> <ul style="list-style-type: none"><li>• DSP #49 stated, "I don't know." (Individual #10)</li></ul>		
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Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: D		
<p><b>NMAC 7.1.12.8</b>  <b>REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:</b> 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.</p> <p>A. <b>Provider requirement to inquire of registry.</b> 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.</p> <p>B. <b>Prohibited employment.</b> 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.</p> <p>D. <b>Documentation of inquiry to registry.</b> 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.</p>	<p>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 6 of 53 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> <li>• #52 – Date of hire 06/01/2007</li> <li>• #60 – Date of hire 09/01/2006</li> <li>• #62 – Date of hire 05/22/2008</li> <li>• #65 – Date of hire 11/15/2006</li> <li>• #75 – Date of hire 11/20/2006</li> <li>• #77 – Date of hire 06/01/2006</li> </ul>		

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.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007

**Chapter 1.IV. General Provider Requirements.**

**D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: D		
<p><b>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b></p> <p><b>A. General:</b> All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p><b>D. Training Documentation:</b> All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</p>	<p>Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 2 of 53 Agency Personnel.</p> <ul style="list-style-type: none"> <li>Incident Management Training (Abuse, Neglect &amp; Misappropriation of Consumers' Property) (#71)</li> </ul> <p>When DSP were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect &amp; Misappropriation of Consumers' Property, the following was reported:</p> <ul style="list-style-type: none"> <li>DSP #43 stated, "I would call my service coordinator and DHI." (DSP failed to mention Adult Protective Services)</li> </ul>		

Tag # 1A28 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: D		
<p><b>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b></p> <p><b>A. General:</b> All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p><b>E. Consumer and Guardian Orientation Packet:</b> 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.</p>	<p>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 15 individuals.</p> <ul style="list-style-type: none"> <li>• Parent/Guardian Incident Management Training (Abuse, Neglect &amp; Misappropriation of Consumers' Property) (#3)</li> </ul>		

Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: D		
<p><b>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:</b></p> <p>A. A service provider shall not restrict or limit a client's rights except:</p> <p>(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or</p> <p>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or</p> <p>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].</p> <p>B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy.</p> <p>C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p><b>Long Term Services Division Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003</b></p> <p><b>IV. POLICY STATEMENT</b> Human Rights Committees are required for</p>	<p>Based on record review, the Agency failed to ensure the rights of Individuals was not restricted or limited for 1 of 15 Individuals. (Individual #13)</p> <p>A review of Agency Individual files indicated 1 of 15 Individuals required Human Rights Committee Approval for restrictions.</p> <p>No documentation was found regarding Human Rights Approval for the following:</p> <ul style="list-style-type: none"> <li>• Psychotropic Medications to control behaviors. No evidence found of Human Rights Committee approval. (Individual #13)</li> </ul>		

residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:

- Aversive Intervention Prohibitions
- Psychotropic Medications Use
- Behavioral Support Service Provision.

A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up.

**A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS**

Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval.

2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly.

3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual's Individual Service Plan

Tag # 1A33 Board of Pharmacy - Med Storage	Scope and Severity Rating: A		
<p><b>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual</b></p> <p><b>E. Medication Storage:</b></p> <ol style="list-style-type: none"> <li>1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee.</li> <li>2. Drugs to be taken by mouth will be separate from all other dosage forms.</li> <li>3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature.</li> <li>4. Separate compartments are required for each resident's medication.</li> <li>5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day.</li> <li>6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist.</li> </ol>	<p>Based on record review and observation, the Agency failed to ensure proper storage of medication for 2 of 12 individuals.</p> <p>Observation included:</p> <p>Individual #5 Medications were not stored in a locked area. The Agency Policy states, "Medications will be locked in the designated area in each home (e.g., locked closet, file cabinet)."</p> <p>Individual #10 Medications were not stored in a locked area. The Agency Policy states, "Medications will be locked in the designated area in each home (e.g., locked closet, file cabinet)."</p>		

Tag # 1A36 SC Training	Scope and Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p><b>C. Orientation and Training Requirements:</b> Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training <b>Requirements for Direct Support Staff and Internal Service Coordinators</b> Serving Individuals with Developmental Disabilities to include the following:</p> <p>(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</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 3 Service Coordinators.</p> <p>Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:</p> <ul style="list-style-type: none"> <li>• Promoting Effective Teamwork (SC #92)</li> </ul>		

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: D	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p><b>C. Orientation and Training Requirements:</b> Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(2) <b>Individual-specific training</b> for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy</p> <p><b>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</b></p> <p><b>II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications</p>	<p>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 1 of 53 Agency Personnel.</p> <p>Review of personnel records found no evidence of the following:</p> <ul style="list-style-type: none"> <li>• Individual Specific Training (#47)</li> </ul>	

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 DDS-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDS-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 DDS-approved medication course in accordance with the DDS 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. The training shall address at least the following:

1. Operating a fire extinguisher
2. Proper lifting procedures
3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat)
4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines)

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

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</b></p> <p><b>G. Health Care Requirements for Community Living Services.</b></p> <p>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first.</p> <p>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <p>(a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community</p>	<p>Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 5 of 15 individuals receiving Community Living Services.</p> <ul style="list-style-type: none"> <li>• <b>Annual Physical (#7)</b></li> <li>• <b>Dental Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #3 - As indicated by the ISP, individual required a dental exam. No evidence of exam was found.</li> <li>◦ Individual #9 - As indicated by the documentation reviewed, exam was completed on 02/01/2008. Follow-up was to be completed in 1 year. No evidence of follow-up found.</li> </ul> </li> <li>• <b>Bone Density Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #9 - As indicated by the documentation reviewed, exam was completed on 06/06/2008. Follow-up was to be completed in 1 year. No evidence of follow-up found.</li> </ul> </li> <li>• <b>Blood Levels</b> <ul style="list-style-type: none"> <li>◦ Individual #3 - As indicated by the documentation reviewed, labs were ordered on 01/2009. No evidence of labs being completed was found.</li> <li>◦ Individual #4 - As indicated by the documentation reviewed, labs were ordered on 11/25/2008. No evidence of labs being completed was found.</li> </ul> </li> <li>• <b>Review of Psychotropic Medication</b> <ul style="list-style-type: none"> <li>◦ Individual #2 - According to documentation</li> </ul> </li> </ul>		

<p>Inclusion Services and Private Duty Nursing Services.</p> <p>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.</p> <p>(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <p>(a) The individual has a primary licensed physician;</p> <p>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</p> <p>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</p> <p>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</p> <p>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</p>	<p>reviewed Individual #2 is to have a medication review every 6-months. No evidence was found for the following time frame to indicate they were completed (07/2008 - 06/2009).</p>		
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Tag # 6L14 Residential Case File	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>A. Residence Case File:</b> For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:</p> <p>(1) Complete and current ISP and all supplemental plans specific to the individual;</p> <p>(2) Complete and current Health Assessment Tool;</p> <p>(3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;</p> <p>(4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);</p> <p>(5) Data collected to document ISP Action Plan implementation</p> <p>(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 9 of 12 Individuals receiving Family Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• Current Emergency &amp; Personal Identification Information <ul style="list-style-type: none"> <li>◦ Did not contain Pharmacy Information (#2 &amp; 5)</li> </ul> </li> <li>• Annual ISP (#8 &amp; 13)</li> <li>• ISP Signature Page (#1, 2, 8, 9, 12 &amp; 13)</li> <li>• Addendum A (#1, 2, 5, 8, 9 &amp; 15)</li> <li>• Individual Specific Training (Addendum B) (#8 &amp; 13)</li> <li>• Teaching &amp; Support Strategies (#1, 8, 9 &amp; 14)</li> <li>• Positive Behavioral Plan (#1)</li> <li>• Positive Behavioral Crisis Plan (#1)</li> <li>• Speech Therapy Plan (#1 &amp; 9)</li> <li>• Occupational Therapy Plan (#9)</li> <li>• Health Assessment Tool (#8, 9, 12 &amp; 14)</li> <li>• <b>Special Health Care Needs</b> <ul style="list-style-type: none"> <li>◦ Meal Time Plan (#9)</li> <li>◦ Nutritional Plan (#9)</li> </ul> </li> <li>• <b>Health Care Plans</b> <ul style="list-style-type: none"> <li>◦ Assistance with ADLs (#1)</li> </ul> </li> </ul>		

<p>least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> <li>(a) The name of the individual;</li> <li>(b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;</li> <li>(c) Diagnosis for which the medication is prescribed;</li> <li>(d) Dosage, frequency and method/route of delivery;</li> <li>(e) Times and dates of delivery;</li> <li>(f) Initials of person administering or assisting with medication; and</li> <li>(g) An explanation of any medication irregularity, allergic reaction or adverse effect.</li> <li>(h) For PRN medication an explanation for the use of the PRN must include: <ul style="list-style-type: none"> <li>(i) Observable signs/symptoms or circumstances in which the medication is to be used, and</li> <li>(ii) Documentation of the effectiveness/result of the PRN delivered.</li> </ul> </li> <li>(i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis.</li> </ul> <p>(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current</p>	<ul style="list-style-type: none"> <li>◦ Cyst on right side of abdomen (#1)</li> <li>◦ HAT Level 4 (#9)</li> </ul> <ul style="list-style-type: none"> <li>• <b>Crisis Plan</b> <ul style="list-style-type: none"> <li>◦ Allergies (#2)</li> <li>◦ Seizures (#2)</li> <li>◦ Cardiac Condition (#2 &amp; 9)</li> <li>◦ Potential for Deterioration in Health (#9)</li> <li>◦ CPAP needed for Sleep Apnea (#9)</li> </ul> </li> <li>• <b>Progress Notes/Daily Contacts Logs:</b> <ul style="list-style-type: none"> <li>◦ Individual #1 - None found for June 2009</li> <li>◦ Individual #8 - None found for June 2009</li> <li>◦ Individual #14 - Not Complete for July 2009</li> </ul> </li> <li>• <b>Data Collection/Data Tracking:</b> <ul style="list-style-type: none"> <li>◦ Individual #9 - None found for June 2009</li> </ul> </li> <li>• <b>Progress Notes written by DSP and/or Nurses regarding Health Status:</b> <ul style="list-style-type: none"> <li>◦ Individual #9 - None found for June 2009</li> </ul> </li> <li>• Health Care Providers Written Orders (#9)</li> <li>• Record of visits of healthcare practitioners (#1)</li> <li>• <b>Medication Administration Record (MAR)</b> <ul style="list-style-type: none"> <li>◦ Individual #9 - None found for May &amp; June 2009.</li> </ul> </li> </ul>		
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ISP year; and  
(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.

Tag # 6L25 (CoP) Residential Health & Safety (Family Living)	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS L. Residence</b></p> <p><b>Requirements for Family Living Services and Supported Living Services</b></p> <p>(1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has:</p> <p>(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;</p> <p>(b) General-purpose first aid kit;</p> <p>(c) When applicable due to an individual's health status, a blood borne pathogens kit;</p> <p>(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;</p> <p>(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;</p> <p>(f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;</p> <p>(g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and</p> <p>(h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.</p>	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 7 of 12 Family Living residences.</p> <p>The following items were not found, not functioning or incomplete:</p> <ul style="list-style-type: none"> <li>• General-purpose first aid kit (#1)</li> <li>• Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#9)</li> <li>• 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 (#1, 9 &amp; 15)</li> <li>• Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#1, 5, 8, 12 &amp; 15)</li> <li>• Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#5, 9 &amp; 10)</li> </ul>		

Tag # 6L28 IL Reimbursement	Scope and Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES</b></p> <p>D. Reimbursement for Independent Living Services: The billable unit for Independent Living Services is a monthly rate with a maximum of 12 units a year. Independent Living Services is reimbursed at two levels based on the number of hours of service needed by the individual as specified in the ISP. An individual receiving at least 20 hours but less than 100 hours of direct service per month will be reimbursed at Level II rate. An individual receiving 100 or more hours of direct service per month will be reimbursed at the Level I rate.</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Independent Living Services for 1 of 3 individuals.</p> <p>Individual #3 May 2009</p> <ul style="list-style-type: none"> <li>Per Individual's budget the individual is to receive Regular Independent Living (no less than 20 hours of service a month). Agency billed 1 unit of Independent Living. Documentation received accounted for 17.25 hours.</li> </ul>		



Alfredo Vigil, MD  
Secretary

DEPARTMENT OF

Building a Healthy New Mexico!

Bill Richardson, Governor



Katrina Hotrum  
Deputy Secretary

Duffy Rodriguez  
Deputy Secretary

Jessica Sutin  
Deputy Secretary

Karen Armitage, MD  
Chief Medical Officer

Date: October 20, 2009  
To: Patrick Garrity, Executive Director  
Provider: Ability First, LLC  
Address: P.O. Box 30866  
State/Zip: Albuquerque, New Mexico 87190

RE: Request for an Informal Reconsideration of Findings

Region: Metro/Southwest  
Survey Date: July 13-16, 2009  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Community Living, Community Inclusion  
Survey Type: Routine  
Team Leader: Crystal Lopez-Beck, BS, Healthcare Surveyor  
Regarding Report #: Q10.1.24883310.Met/SW.001.RTN.01

Dear Mr. Garrity,

Your request for a Reconsideration of Findings was received on September 22, 2009. The IRF committee has reviewed your request and the supporting evidence provided. Based on the review of applicable DDS standards and regulations, review of the survey process and the evidence you provided, the committee has made the following determinations:

Regarding Tag #: 1A03

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. The evidence submitted by you for the IRF was dated, the evidence supplied to and copied by the Survey Team during the on-site survey did not contain a date.

Regarding Tag #: 1A05

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. The documentation supplied as evidence for the IRF did not show evidence of the policy being reviewed, dated, etc. Also, the evidence submitted states the policy and procedure "will be" reviewed, not evidence that it was done.

Regarding Tag #: 1A06

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. While the identifying number should be changed from #14 to #42, the deficiency remains.

Regarding Tag #: 1A08

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. Documents requested from your agency on 7/16/09, and signed by "PG" were not received by the exit meeting.

Regarding Tag #: 1A09 (a)

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. Documents previously requested from your agency were not received by the exit meeting.

Regarding Tag #: 1A09 (b)

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. The documentation supplied as evidence for the IRF was for Individual #12, the deficiency in the report was for Individual #9.

Regarding Tag #: 1A09(c)

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. Documents previously requested from your agency were not received by the exit meeting.

Regarding Tag #: 1A09 (d)

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. Documents requested from your agency representative during a residential visit could not be provided for the Survey Team. The request was signed by Shirley Ann Rendon on 7/15/09.

Regarding Tag #: 1A09 (e)

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. The documentation supplied as evidence for the IRF did not justify the request for an IRF; no evidence of PCP orders was found in the residence. If a physician refuses to create a written record of a medication order we suggest you contact the regional office for technical assistance.

Regarding Tag #: 1A11 (a)

Determination: The IRF committee is modifying the original finding in the report. You are required to complete your remaining Plan of Correction as previously indicated. The following staff will be removed from the original deficiency: #42, 43, 45, 86, 87, 88 and 89. Documentation submitted for #46 was not graded or signed by the instructor. Deficiencies for the following staff will remain: #40, 44, 49-53, 57-62, 64, 66, 71, 72, 80, 81 and 83. The scope and severity rating will remain an "E" for this deficiency.

Regarding Tag #: 1A11 (b)

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. The documentation supplied as evidence for the IRF did not justify the request for an IRF. During the on-site survey staff interviewed were not competent in questions posed to them about safe transportation of Individuals served by your agency.

Regarding Tag #: 1A12

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. Regardless of actions from the last survey applicable standards state the requirement for a signature is needed every day (one billable unit) the person is served by your agency, not one signature at the end of any other given time period; in your circumstance one month.

Regarding Tag #: 1A15 (a)

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. The documentation supplied as evidence for the IRF did not justify the request for an IRF. During the on-site survey staff interviewed did not know how to get in touch with your agency nurse, despite any training you may have supplied.

Regarding Tag #: 1A15 (b)

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. Documents requested from your agency representative during a residential visit could not be provided for the Survey Team. The request was signed by Janice Whitting on 7/15/09.

Regarding Tag #: 1A15 (c)

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. Documentation submitted by your agency for the IRF include an outdated internal healthcare plan, despite the contents of this internal document the Individual Specific Training (IST) section of the Individual Service Plan (ISP) in question, effective dates 10/9/08 to 10/8/09 state crisis plans are required.

Regarding Tag #: 1A26

Determination: The IRF committee is modifying the original finding in the report. You are required to complete your remaining Plan of Correction as previously indicated. The following staff will be removed from the original deficiency: #77. Deficiencies for the following staff will remain: #52, 60, 62, 65, 75, 77. The scope and severity rating will remain a "D" for this deficiency.

Regarding Tag #: 1A28 (a)

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. Documents previously requested from your agency were not received by the exit meeting.

Regarding Tag #: 1A28 (b)

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. Documents previously requested from your agency regarding #71 were not received by the exit meeting.

Regarding Tag #: 1A28 (c)

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. Documents submitted by your agency regarding #43 do not change the fact that they lacked competency during an interview with the Survey Team.

Regarding Tag #: 1A31

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. Documents previously requested from your agency were not received by the exit meeting.

Regarding Tag #: 1A37

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. Documents previously requested from your agency were not received by the exit meeting.

Regarding Tag #: 1A36

Determination: The IRF committee is removing the original finding in the report.

Regarding Tag #: 6L14

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. Documents requested from your agency representative during residential visits could not be provided for the Survey Team. The requests were signed by:

- For #1, Barbara Candelaria on 7/16/09
- For #2, Gloria Candelaria on 7/15/09
- For #5, Steven Knight on 7/14/09
- For #9, Janice Whitting on 7/15/09
- For #13, Helen Tedla on 7/14/09
- For #14, Donna Wagner on 7/14/09

Regarding Tag #: 6L13 (a)

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. The document supplied by your agency for consideration failed to mention and did not excuse the absence of a dental exam or results of blood levels from the file of Individual #3.

Regarding Tag #: 6L13 (b)

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. No note indicating the discontinuation of the medication was found in the residential file at the time of the survey. The documentation supplied by you is dated a full two months after the on-site survey took place.

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

Thank you.

Respectfully,

*Scott Good, MRC, CRC*

Scott Good, MRC, CRC  
Deputy Bureau Chief  
Informal Reconsideration of Finding Committee Chair

CC:  
DDSD  
Dan Maxwell, MS, Quality Management Bureau Chief  
Crystal Lopez-Beck, Survey Team Lead  
Valerie Valdez, Health Program Manager  
George Perrault, Plan of Correction Coordinator

