

Date: May 17, 2010

To: Jonathon Baca, Director  
Provider: Achievements, Inc.  
Address: 6616 Gulton Ct. NE  
State/Zip: Albuquerque, NM 87109

E-mail Address: [jbaca02@unm.edu](mailto:jbaca02@unm.edu)

CC: Kimberly Allen, Executive Director, CEO  
Address: 6616 Gulton Ct. NE  
State/Zip: Albuquerque, NM 87109

E-Mail Address: [kimberlyallenm@gmail.com](mailto:kimberlyallenm@gmail.com)

Region: Metro  
Survey Date: April 26 - 29, 2010  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Community Living (Supported Living) & Community Inclusion (Adult Habilitation)  
Survey Type: Routine  
Team Leader: Maurice Gonzales, BS Health Ed., Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Team Members: Stephanie Berenger, MBA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Angie Helewicz, Behavioral Liaison, Developmental Disabilities Support Division

Dear Mr. Baca,

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

**Quality Management Approval Rating:**

The Division of Health Improvement is issuing your agency a finding of "NON-COMPLIANCE" for basic compliance with DDSD Standards and regulations.

**Plan of Correction:**

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

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



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

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

Quality Management Bureau • 5301 Central Ave. NE Suite 400 • Albuquerque, New Mexico 87108  
(505) 222-8623 • FAX: (505) 222-8661 • <http://dhi.health.state.nm.us>

DHI Quality Review Survey Report – Achievements, Inc. - Metro Region – April 26 – 29, 2010

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

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

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

**Request for Informal Reconsideration of Findings (IRF):**

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

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

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

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

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

Please call the Team Leader at 505-231-6167, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

*Maurice Gonzales, BS Health Ed.*

Maurice Gonzales, BS Health Ed.  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: April 26, 2010

Present: **Achievements, Inc.**  
Jonathon Baca, Director  
Matthew Suazo, Program Manager

**DOH/DHI/QMB**

Maurice Gonzales, BS Health Ed., Team Lead/Healthcare Surveyor  
Stephanie Berenger, MBA, Healthcare Surveyor

**DDSD - Metro Regional Office**

Angie Helewicz, Behavioral Liaison, Developmental Disabilities  
Support Division

Exit Conference Date: April 28, 2010

Present: **Achievements, Inc.**  
Kimberly Allen, Executive Director, CEO  
Jonathon Baca, Director  
Jaime Barron, CFO  
Matthew Suazo, Program Manager

**DOH/DHI/QMB**

Maurice Gonzales, BS Health Ed. Team Lead/Healthcare Surveyor  
Stephanie Berenger, MBA, Healthcare Surveyor

**DDSD - Metro Regional Office**

Angie Helewicz, Behavioral Liaison, Developmental Disabilities  
Support Division

Homes Visited Number: 3

Administrative Locations Visited Number: 1

Total Sample Size Number: 5  
2 - Jackson Class Members  
3 - Non-Jackson Class Members  
5 - Supported Living  
2 - Adult Habilitation

Persons Served Interviewed Number: 2

Persons Served Observed Number: 3 (3 Individuals chose not to participate in the interview process)

Records Reviewed (Persons Served) Number: 5

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

##### “Compliance”

“Compliance” indicates that a provider is in compliance with all ‘Conditions of Participation’ and substantial compliance with other standards and regulations. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals’ health and safety. To be in “Compliance” the provider must not have any findings that are a Condition of Participation.

##### “Partial Compliance”

“Substantial Compliance” also know as, “Partial Compliance” indicates a provider has obtained a minimum level of compliance, but still has isolated Conditions of Participation out of compliance. This isolated non-compliance if not corrected is a potential for more than minimal harm (scope/severity level “D”) to individuals’ health and safety. A provider in Substantial Compliance may have any number of “D” level Conditions of Participation out of compliance, but no Conditions higher than “D” level.

“Non-Compliance”

“Non-Compliance” indicates that a provider is out of compliance with one or more Conditions of Participation and/or other additional standards and regulations. This non-compliance if not corrected is a potential for more than minimal harm (scope/severity level “E” or “F”) to individuals’ health and safety.

Providers having repeat Non-compliance findings may be referred by QMB to the Internal Review Committee (IRC) for potential actions and sanctions, including but not limited to:

- Repeat findings of Conditions of Participation
- A pattern of repeat findings

## **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:** Achievements, Inc. - Metro Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Living (Supported Living) & Community Inclusion (Adult Habilitation)  
**Monitoring Type:** Routine Survey  
**Date of Survey:** April 26 - 29, 2010

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: E	Agency Plan of Correction and Person Responsible	Date Due
<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</p>	<p>Medication Administration Records (MAR) were reviewed for the months of January, February &amp; March 2010.</p> <p>Based on record review, 3 of 5 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #1 January 2010</p> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Gabapentin 300mg (2 times daily) – Blank 1/20 (12 PM)</li> <li>• Buspirone HCL 15mg (3 times daily) – Blank 1/20 (12 PM)</li> <li>• Lorazepam 2mg (3 times daily) – Blank 1/20 (12 PM)</li> <li>• Aquaphor Ointment 14oz. (3 times daily) – Blank 1/20 (12 PM)</li> <li>• Ensure RTU Liquid- 1 can (3 times daily) – Blank 1/20 (12 PM)</li> <li>• Resource Beneprotein Powder- 1 tbs w/food (3 times daily) – Blank 1/20 (12 PM)</li> <li>• Thick-It Regular Strength- w/liquids (3 times</li> </ul>		

<p>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 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> </ul>	<p>daily) – Blank 1/20 (12 PM)</p> <p>March 2010  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Calcium w/Vitamin D 600mg/400IU-2 tablets (2 times daily) – Blank 3/26 (7 AM)</li> </ul> <p>Individual #2  March 2010  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Desmopressin 0.1mg/ml spray (2 times daily) – Blank 3/8 (PM)</li> </ul> <p>Individual #4  March 2010  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Trihexyphenidyl 5mg (3 times daily) – Blank 3/30 (4 PM)</li> </ul>		
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- (v) Strength of drug;
- (vi) Route of administration;
- (vii) How often medication is to be taken;
- (viii) Time taken and staff initials;
- (ix) Dates when the medication is discontinued or changed;
- (x) The name and initials of all staff administering medications.

**Model Custodial Procedure Manual**

***D. Administration of Drugs***

Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

Tag # 1A09 Medication Delivery - PRN Medication	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> </ol>	<p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 3 of 5 Individuals.</p> <p>Individual #2 January 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Pink Bismuth B-L (PRN)</p> <p>February 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Pink Bismuth B-L (PRN)</p> <p>March 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Pink Bismuth B-L (PRN)</p> <p>Individual #3 January 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Pink Bismuth B-L (PRN)</p> <p>February 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Pink Bismuth B-L (PRN)</p> <p>March 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour</p>		

<p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</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: 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</li> </ul>	<p>period: •Pink Bismuth B-L (PRN)</p> <p>Individual #5 January 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: •Pink Bismuth B-L (PRN)</p> <p>February 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: •Pink Bismuth B-L (PRN)</p> <p>March 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: •Pink Bismuth B-L (PRN)</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication: •Acetaminophen 500mg – PRN – 3/6 &amp; 16 (given 1 time)</p> <p>•Alka Seltzer Cold Plus – PRN – 3/7 (given 2 times) &amp; 3/9, 13 &amp; 14 (given 1 time)</p> <p>During on-site survey (April 26 - 29, 2010) Physician Orders were requested. As of 4/29/2010, Physician Orders had not been provided. •Alka Seltzer Cold Plus – PRN</p>		
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- or changed;
- (x) The name and initials of all staff administering medications.

**Model Custodial Procedure Manual**

***D. Administration of Drugs***

Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

**Department of Health**

**Developmental Disabilities Supports Division**

**(DDSD) Medication Assessment and Delivery**

**Policy - Eff. November 1, 2006**

**F. PRN Medication**

3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.

4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy).

**H. Agency Nurse Monitoring**

1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication.

**Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006**

C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention.

(References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).

a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.

4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).

Tag # 1A20 DSP Training Documents	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>C. Orientation and Training Requirements:</b> Orientation and training for direct support staff and his or her supervisors shall comply with the DDS/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><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - 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 described in the</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 13 of 48 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>• Basic Health/Orientation (DSP #84)</li> <li>• First Aid (DSP #40, 41, 49, 53, 54, 66, 73, 77, 79, 81 &amp; 82)</li> <li>• CPR (DSP #41, 47, 49, 53, 54, 66, 73, 77, 79, 81 &amp; 82)</li> <li>• Assisting With Medication Delivery (DSP #77 &amp; 81)</li> </ul>		

individual service plan (ISP) of each individual served.

C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.

D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.

E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.

F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.

G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.

H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.

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

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D		
<p><b>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:</b>  <b>F. Timely Submission:</b> Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</p> <p><b>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:</b>  <b>A. Prohibition on Employment:</b> A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</p> <p><b>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.</b>  The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:  <b>A.</b> homicide;  <b>B.</b> trafficking, or trafficking in controlled substances;  <b>C.</b> kidnapping, false imprisonment, aggravated assault or aggravated battery;  <b>D.</b> rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;  <b>E.</b> crimes involving adult abuse, neglect or financial exploitation;  <b>F.</b> crimes involving child abuse or neglect;  <b>G.</b> crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or  <b>H.</b> an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p>	<p>Based on record review, the Agency failed to maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 4 of 50 Agency Personnel.</p> <p><b>The following Agency Personnel Files contained Caregiver Criminal History Screenings, which were not specific to the Agency:</b></p> <ul style="list-style-type: none"> <li>• #60 – Date of hire 8/30/2004</li> <li>• #61 – Date of hire 12/10/2003</li> <li>• #75 – Date of hire 1/31/2006</li> <li>• #76– Date of hire 7/12/2009</li> </ul>		

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E		
<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 24 of 50 Agency Personnel.</p> <p><b>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</b></p> <ul style="list-style-type: none"> <li>• #40 – Date of hire 7/10/2009. Completed 7/30/2009.</li> <li>• #42 – Date of hire 11/2/2009. Completed 11/10/2009.</li> <li>• #43 – Date of hire 9/30/2008. Completed 10/1/2008.</li> <li>• #45 – Date of hire 2/3/2009. Completed 2/4/2009.</li> <li>• #52 – Date of hire 3/31/2008. Completed 4/7/2008.</li> <li>• #54 – Date of hire 12/17/2007. Completed 2/18/2008.</li> <li>• #55 – Date of hire 12/2/2008. Completed 12/12/2008.</li> <li>• #56 – Date of hire 7/10/2008. Completed 7/11/2008.</li> <li>• #58 – Date of hire 9/30/2009. Completed 10/13/2009.</li> <li>• #59 – Date of hire 7/28/2009. Completed 7/28/2009.</li> </ul>		

<p>E. <b>Documentation for other staff.</b> 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.</p> <p>F. <b>Consequences of noncompliance.</b> The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>Chapter 1.IV. General Provider Requirements.</b></p> <p><b>D. Criminal History Screening:</b> 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.</p>	<ul style="list-style-type: none"> <li>• #62 – Date of hire 9/4/2009. Completed 10/13/2009.</li> <li>• #67 – Date of hire 11/26/2008. Completed 12/12/2008.</li> <li>• #70 – Date of hire 4/1/2008. Completed 4/8/2008.</li> <li>• #71 – Date of hire 10/8/2009. Completed 10/14/2009.</li> <li>• #73 – Date of hire 1/8/2010. Completed 1/9/2010.</li> <li>• #74– Date of hire 1/21/2010. Completed 1/28/2010.</li> <li>• #81 – Date of hire 1/21/2010. Completed 1/28/2010.</li> <li>• #82 – Date of hire 2/20/2008. Completed 2/26/2008.</li> <li>• #83 – Date of hire 3/8/2010. Completed 4/10/2010.</li> <li>• #84 – Date of hire 4/5/2010. Completed 4/10/10.</li> <li>• #85 – Date of hire 4/5/2010. Completed 4/11/2010.</li> <li>• #86 – Date of hire 1/21/2010. Completed 1/28/2010.</li> <li>• #87 – Date of hire 3/8/2010. Completed 4/10/2010.</li> <li>• #89 – Date of hire 7/28/2009. Completed 7/30/2009.</li> </ul>		
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<b>Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training</b>	<b>Scope &amp; Severity Rating: D</b>		
<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><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>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p>	<p>Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 3 of 50 Agency Personnel.</p> <ul style="list-style-type: none"> <li>• Incident Management Training (Abuse, Neglect &amp; Misappropriation of Consumers' Property) (#53, 70 &amp; 76)</li> </ul>		

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: D		
<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 Inclusion Services and Private Duty Nursing Services.</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 1 of 5 individuals receiving Community Living Services.</p> <ul style="list-style-type: none"> <li>• <b>Pap Smear Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #5 - As indicated by the documentation reviewed, the exam was completed on 3/5/2009. No evidence of exam was found.</li> </ul> </li> </ul>		

<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>			
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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 least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 2 of 5 Individuals receiving Supported Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• Annual ISP (#1)</li> <li>• ISP Signature Page (#1)</li> <li>• Positive Behavioral Plan (#1 &amp; 3)</li> <li>• Positive Behavioral Crisis Plan (#1 &amp; 3)</li> </ul>		

<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 ISP year; and</p> <p>(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</p>			
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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.

<b>Tag # 6L25 (CoP) Residential Health &amp; Safety (Supported Living &amp; Family Living)</b>	<b>Scope and Severity Rating: E</b>		
<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>L. Residence 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> <ul style="list-style-type: none"> <li>(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;</li> <li>(b) General-purpose first aid kit;</li> <li>(c) When applicable due to an individual's health status, a blood borne pathogens kit;</li> <li>(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;</li> <li>(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;</li> <li>(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;</li> <li>(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</li> <li>(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.</li> </ul>	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 3 of 5 Supported Living residences.</p> <p>The following items were not found, not functioning or incomplete:</p> <p><b>Supported Living Requirements:</b></p> <ul style="list-style-type: none"> <li>• Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#2, 4 &amp; 5)</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 (#2, 4 &amp; 5)</li> </ul>		

**ADDITIONAL FINDINGS: Reimbursement Deficiencies**

**BILLING  
TAG #1A12**

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

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

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

Billing for Community Living (Supported Living) and Community Inclusion (Adult Habilitation) services was reviewed for 5 of 5 individuals. Progress notes and billing records supported billing activities for the months of January, February and March 2010.