



Alfredo Vigil, MD
Secretary

DEPARTMENT OF

Building a Healthy New Mexico!

Bill Richardson, Governor

Katrina Hotrum
Deputy Secretary

Jessica Sutin
Deputy Secretary

Michael Mulligan
Acting Deputy Secretary

Karen Armitage, MD
Chief Medical Officer

Date: July 19, 2010

To: Lori Guevara, Director
Provider: Grace Requires Understanding, Inc.
Address: 125 West Mountain
State/Zip: Las Cruces, NM 88005

E-mail Address: grus@zianet.com

CC: Victor Duran, Board Chair
Address: P. O. Box 2334
State/Zip: Mesilla Park, NM 88047

Boardchair
E-Mail Address: victord3@msn.com

Region: Southwest
Survey Date: May 24 – June 1, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Family Living & Independent Living &) & Community Inclusion (Adult Habilitation & Community Access)
Survey Type: Routine
Team Leader: Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Valerie V. Valdez, MS, Healthcare Program Manager, Division of Health Improvement/Quality Management Bureau; Cynthia Neilson, RN, MSN, Healthcare Surveyor/Clinical Liaison; 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; Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Cheryl Dunfee, Case Management Coordinator, Developmental Disabilities Support Division/Southwest Regional Office

Dear Ms. Guevara,

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 Determination:

The Division of Health Improvement/Quality Management Bureau is issuing your agency a determination of "Substandard Compliance with Conditions of Participation."



"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 – Grace Requires Understanding, Inc. - Southwest Region – May 24 – June 1, 2010

Plan of Correction:

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

1. Quality Management Bureau, Attention: Plan of Correction Coordinator
5301 Central Ave. NE Suite 400 Albuquerque, NM 87108
2. Developmental Disabilities Supports Division Regional Office for region of service surveyed.

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

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

Request for Informal Reconsideration of Findings (IRF):

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

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

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

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

Please call the Team Leader at 505-690-4693, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Deb Russell, BS

Deb Russell, BS
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date: May 24, 2010

Present: **Grace Requires Understanding, Inc.**
Lori Guevara, Director
Mark Chavez, General Manager

DOH/DHI/QMB

Deb Russell, BS, Team Lead/Healthcare Surveyor
Valerie Valdez, MS, Program Manager/Healthcare Surveyor

DDSD - Southwest Regional Office

Cheryl Dunfee, Case Management Coordinator

Exit Conference Date: May 26, 2010

Present: **Grace Requires Understanding, Inc.**
Lori Guevara, Director

Mark Chavez, General Manager
Margie Barela, Day Hab Director
Lupe Ordunez, Training Coordinator
JoAnna D. Tarango, Family Support Manager
James Harkness, Family Living Provider/Board Vice President
Victor Duran, Family Living Provider/Board Chair
Dolores Ordunez, Office Manager
Cruz Maria Rias, Family Support Manager
Brinton Mowles, Family Support Manager

DOH/DHI/QMB

Deb Russell, BS, Team Lead/Healthcare Surveyor
Valerie Valdez, MS, Program Manager/ Healthcare Surveyor
Cynthia Nielsen, RN, Healthcare Surveyor /Clinical Liaison
Barbara Czinger, LISW, Healthcare Surveyor
Florie Alire, RN, Healthcare Surveyor
Nadine Romeo, LBSW, Healthcare Surveyor

DDSD - Southwest Regional Office

Cheryl Dunfee, Case Management Coordinator

Homes Visited Number: 15

Administrative Locations Visited Number: 1

Total Sample Size Number: 20
0 - Jackson Class Members
20 - Non-Jackson Class Members
19 - Family Living
1 – Independent Living
2 - Adult Habilitation
7 - Community Access

Persons Served Interviewed Number: 12

Persons Served Observed Number: 8 (2 Individuals were unable to respond to Surveyor's Questions & 6 Individuals were not available during the on-site visit)

Records Reviewed (Persons Served) Number: 20

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.
- 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:

“Substantial Compliance with Conditions of Participation”

The QMB determination of “Substantial Compliance with Conditions of Participation” indicates that a provider is in substantial compliance with all ‘Conditions of Participation’ and 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 qualify for a determination of Substantial Compliance with Conditions of Participation, the provider must not have any findings that meet the thresholds for determining non-compliance with any Condition of Participation.

“Non-Compliance with Conditions of Participation”

The QMB determination of “Non-Compliance with Conditions of Participation” indicates that a provider is out of compliance with one (1) or more ‘Conditions of Participation.’ This non-compliance, if not corrected, is likely to result in a serious negative outcome or the potential for more than minimal harm to individuals’ health and safety.

Providers receiving a repeat determination of Non-Compliance may be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

“Sub-Standard Compliance with Conditions of Participation”:

The QMB determination of “Sub-Standard Compliance with Conditions of Participation” indicates a provider is significantly out of compliance with Conditions of Participation and/or has:

Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm. Any finding of actual harm or Immediate Jeopardy.

Providers receiving a repeat determination of 'Substandard Compliance' will be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

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.

Agency: Grace Requires Understanding, Inc. - Southwest Region
Program: Developmental Disabilities Waiver
Service: Community Living (Family Living & Independent Living) & Community Inclusion (Adult Habilitation & Community Access)
Monitoring Type: Routine Survey
Date of Survey: May 24 – June 1, 2010

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<p>Tag # 1A08 Agency Case File</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;</p>	<p>Scope and Severity Rating: B</p> <p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 7 of 20 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"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ None Found (#4) • ISP Signature Page (#20) • Individual Specific Training Section of ISP (formerly Addendum B) (#1) • ISP Teaching & Support Strategies <ul style="list-style-type: none"> ◦ Individual #3 - TASS not found for: <ul style="list-style-type: none"> ➢ Look for Volunteer Job ◦ Individual #7 - TASS not found for: <ul style="list-style-type: none"> ➢ Research Issues for Upcoming Election ➢ Choose Party Affiliation • Positive Behavioral Crisis Plan (#4) • Occupational Therapy Plan (#3, 11 & 13) 		

<p>(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);</p> <p>(3) Progress notes and other service delivery documentation;</p> <p>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</p> <p>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</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"> (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital. 			
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Tag # 1A08 Agency Case File - Progress Notes	Scope & Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</p> <p>(3) Progress notes and other service delivery documentation;</p>	<p>Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 3 of 20 Individuals.</p> <p>Community Access Progress Notes/Daily Contact Logs</p> <ul style="list-style-type: none"> • Individual #3 - None found for 1/2010 – 4/2010 • Individual #4 - None found for 1/2010 – 4/2010 • Individual #5 - None found for 1/2010 – 3/2010 		

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: F		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</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</p>	<p>Medication Administration Records (MAR) were reviewed for the months of January, February & March 2010.</p> <p>Based on record review, 17 of 20 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 did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Depakote 500mg (2 times daily) • Lamictal 25mg (2 times daily) • Vitamin Supplement <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Vitamin Supplement <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Vitamin Supplement <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Depakote 500mg (2 times daily) • Lamictal 25mg (2 times daily) • Vitamin Supplement <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p>		

<p>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>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued 	<ul style="list-style-type: none"> • Depakote 500mg (2 times daily) • Lamictal 25mg (2 times daily) • Vitamin Supplement <p>February 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Depakote 500mg (2 times daily) • Lamictal 25mg (2 times daily) • Vitamin Supplement <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Vitamin Supplement <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Vitamin Supplement <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Depakote 500mg (2 times daily) • Lamictal 25mg (2 times daily) • Vitamin Supplement <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Depakote 500mg (2 times daily) • Lamictal 25mg (2 times daily) • Vitamin Supplement 		
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<p>or changed;</p> <p>(x) The name and initials of all staff administering medications.</p> <p>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.</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"> ➤ 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. 	<p>March 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Depakote 500mg (2 times daily) • Lamictal 25mg (2 times daily) • Vitamin Supplement <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Vitamin Supplement <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Vitamin Supplement <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Depakote 500mg (2 times daily) • Lamictal 25mg (2 times daily) • Vitamin Supplement <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Depakote 500mg (2 times daily) • Lamictal 25mg (2 times daily) • Vitamin Supplement <p>Individual #2 January 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is</p>		
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	<p>prescribed:</p> <ul style="list-style-type: none"> • Phenobarb 20mg • Tamoxifen 20mg • Lactulose 10gm • Dok 100mg • Fexofenidine 60mg <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Phenobarb 20mg • Tamoxifen 20mg • Lactulose 10gm • Dok 100mg • Fexofenidine 60mg <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Phenobarb 20mg • Tamoxifen 20mg • Lactulose 10gm • Dok 100mg • Fexofenidine 60mg <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Phenobarb 20mg 		
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	<ul style="list-style-type: none"> • Tamoxifen 20mg • Lactulose 10gm • Dok 100mg • Fexofenidine 60mg <p>February 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Phenobarb 20mg • Tamoxifen 20mg • Lactulose 10gm • Dok 100mg • Fexofenidine 60mg <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Phenobarb 20mg • Tamoxifen 20mg • Lactulose 10gm • Dok 100mg • Fexofenidine 60mg <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Tamoxifen 20mg 		
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	<ul style="list-style-type: none"> • Lactulose 10gm • Dok 100mg • Fexofenidine 60mg <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Phenobarb 20mg • Tamoxifen 20mg • Lactulose 10gm • Dok 100mg • Fexofenidine 60mg <p>March 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Phenobarb 20mg • Tamoxifen 20mg • Lactulose 10gm • Dok 100mg • Fexofenidine 60mg <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Phenobarb 20mg • Tamoxifen 20mg • Lactulose 10gm 		
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	<ul style="list-style-type: none"> • Dok 100mg • Fexofenidine 60mg <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Tamoxifen 20mg • Lactulose 10gm • Dok 100mg • Fexofenidine 60mg <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Phenobarb 20mg • Tamoxifen 20mg • Lactulose 10gm • Dok 100mg • Fexofenidine 60mg <p>Individual #3 January 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Potassium Chloride 10mg (1 time daily) • Hydrochora Thiazide 25mg (1 time daily) • Benazepril 10mg (1 time daily) 		
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	<ul style="list-style-type: none"> • Simvastatnon 10mg (1 time daily) • Lotrel 5-20mg (2 times daily) • Vitamin C 1000mg (1 time daily) • Vitamin E 400mg (1 time daily) • Vitamin B12 100mg (1 time daily) • Vitamin B6 100mg (1 time daily) • Metamucil Capsules (2 times daily) <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Stool Softener <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Stool Softener <ul style="list-style-type: none"> • Allergy Tablets (1 time daily) • Metamucil Capsules (2 times daily) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Potassium Chloride 10mg (1 time daily) • Hydrochora Thiazide 25mg (1 time daily) • Benazepril 10mg (1 time daily) • Simvastatnon 10mg (1 time daily) • Lotrel 5-20mg (2 times daily) • Vitamin C 1000mg (1 time daily) 		
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	<ul style="list-style-type: none"> • Vitamin E 400mg (1 time daily) • Vitamin B12 100mg (1 time daily) • Vitamin B6 100mg (1 time daily) • Metamucil Capsules (2 times daily) • Stool Softener • Allergy Tablets (1 time daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Potassium Chloride 10mg (1 time daily) • Hydrochora Thiazide 25mg (1 time daily) • Benazepril 10mg (1 time daily) • Simvastatnon 10mg (1 time daily) • Lotrel 5-20mg (2 times daily) • Vitamin C 1000mg (1 time daily) • Vitamin E 400mg (1 time daily) • Vitamin B12 100mg (1 time daily) • Vitamin B6 100mg (1 time daily) • Stool Softener <p>February 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p>		
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	<ul style="list-style-type: none"> • Potassium Chloride 10mg (1 time daily) • Hydrochora Thiazide 25mg (1 time daily) • Benazepril 10mg (1 time daily) • Simvastatnon 10mg (1 time daily) • Lotrel 5-20mg (2 times daily) • Vitamin C 1000mg (1 time daily) • Vitamin E 400mg (1 time daily) • Vitamin B12 100mg (1 time daily) • Vitamin B6 100mg (1 time daily) • Metamucil Capsules (2 times daily) <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Stool Softener <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Stool Softener <ul style="list-style-type: none"> • Allergy Tablets (1 time daily) • Metamucil Capsules (2 times daily) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Potassium Chloride 10mg (1 time daily) • Hydrochora Thiazide 25mg (1 time daily) • Benazepril 10mg (1 time daily) 		
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	<ul style="list-style-type: none"> • Simvastatnon 10mg (1 time daily) • Lotrel 5-20mg (2 times daily) • Vitamin C 1000mg (1 time daily) • Vitamin E 400mg (1 time daily) • Vitamin B12 100mg (1 time daily) • Vitamin B6 100mg (1 time daily) • Metamucil Capsules (2 times daily) • Stool Softener • Allergy Tablets (1 time daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Potassium Chloride 10mg (1 time daily) • Hydrochora Thiazide 25mg (1 time daily) • Benazepril 10mg (1 time daily) • Simvastatnon 10mg (1 time daily) • Lotrel 5-20mg (2 times daily) • Vitamin C 1000mg (1 time daily) • Vitamin E 400mg (1 time daily) • Vitamin B12 100mg (1 time daily) • Vitamin B6 100mg (1 time daily) 		
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	<ul style="list-style-type: none"> • Stool Softener <p>March 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Potassium Chloride 10mg (1 time daily) • Hydrochora Thiazide 25mg (1 time daily) • Benazepril 10mg (1 time daily) • Simvastatnon 10mg (1 time daily) • Lotrel 5-20mg (2 times daily) • Vitamin C 1000mg (1 time daily) • Vitamin E 400mg (1 time daily) • Vitamin B12 100mg (1 time daily) • Vitamin B6 100mg (1 time daily) • Metamucil Capsules (2 times daily) <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Stool Softener <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Stool Softener • Allergy Tablets (1 time daily) • Metamucil Capsules (2 times daily) <p>Medication Administration Records did not contain the route of administration for the</p>		
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	<p>following medications:</p> <ul style="list-style-type: none"> • Potassium Chloride 10mg (1 time daily) • Hydrochora Thiazide 25mg (1 time daily) • Benazepril 10mg (1 time daily) • Simvastatnon 10mg (1 time daily) • Lotrel 5-20mg (2 times daily) • Vitamin C 1000mg (1 time daily) • Vitamin E 400mg (1 time daily) • Vitamin B12 100mg (1 time daily) • Vitamin B6 100mg (1 time daily) • Metamucil Capsules (2 times daily) • Stool Softener • Allergy Tablets (1 time daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Potassium Chloride 10mg (1 time daily) • Hydrochora Thiazide 25mg (1 time daily) • Benazepril 10mg (1 time daily) • Simvastatnon 10mg (1 time daily) • Lotrel 5-20mg (2 times daily) • Vitamin C 1000mg (1 time daily) 		
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	<ul style="list-style-type: none"> • Vitamin E 400mg (1 time daily) • Vitamin B12 100mg (1 time daily) • Vitamin B6 100mg (1 time daily) • Stool Softener <p>Individual #5 January 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Lisinopril 40mg(1 time daily) • HCT2 25mg (1 time daily) • Merapex (1 time daily) <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Merapex 1 tab (1 time daily) <p>Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications:</p> <ul style="list-style-type: none"> • Lisinopril 40mg (1 time daily) • HCT2 25mg (1 time daily) <p>February 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Lisinopril 40mg(1 time daily) • HCT2 25mg (1 time daily) • Merapex (1 time daily) 		
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	<ul style="list-style-type: none"> • Metformin 500mg (2 times daily) <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Merapex 1 tab (1 time daily) <p>Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications:</p> <ul style="list-style-type: none"> • Lisinopril 40mg(1 time daily) • HCT2 25mg (1 time daily) • Metformin 500mg (2 times daily) <p>March 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Lisinopril 40mg(1 time daily) • Merapex 0.25mg(1 time daily) • Metformin 500mg (2 times daily) <p>Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications:</p> <ul style="list-style-type: none"> • Lisinopril 40mg(1 time daily) • Metformin 500mg (2 times daily) <p>Individual #6 January 2010</p> <p>During on-site survey Medication Administration Records were requested for months of January, February & March 2010. As of June 1, 2010, Medication Administration Records for January had not been provided.</p>		
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	<p>February 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Depakote 1000mg (1 time daily) • Depakote 500mg (2 times daily) • Carbamazepine 200mg (3 times daily) • Synthroid 0.075mg • Folic Acid 1mg <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Synthroid 0.075mg • Folic Acid 1mg <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Depakote 1000mg (1 time daily) • Depakote 500mg (2 times daily) • Carbamazepine 200mg (3 times daily) • Synthroid 0.075mg • Folic Acid 1mg <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Depakote 1000mg (1 time daily) • Depakote 500mg (2 times daily) 		
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	<ul style="list-style-type: none"> • Carbamazepine 200mg (3 times daily) • Synthroid 0.075mg • Folic Acid 1mg <p>March 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Depakote 1000mg (1 time daily) • Depakote 500mg (2 times daily) • Carbamazepine 200mg (3 times daily) • Synthroid 0.075mg (1 time daily) • Folic Acid 1mg (1 time daily) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Depakote 1000mg (1 time daily) • Depakote 500mg (2 times daily) • Carbamazepine 200mg (3 times daily) • Synthroid 0.075mg (1 time daily) • Folic Acid 1mg (1 time daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Depakote 1000mg (1 time daily) • Depakote 500mg (2 times daily) 		
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	<ul style="list-style-type: none"> • Carbamazepine 200mg (3 times daily) • Synthroid 0.075mg (1 time daily) • Folic Acid 1mg (1 time daily) <p>Individual #7 January 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Levinthroid 0.75mg (1 time daily) • Loratidine 0.75mg (1 time daily) <p>February 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Leventhroid 0.75mg • Loratidine 0.10mg <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Levinthroid 0.75mg • Loratidine 0.10mg <p>March 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Levinthroid 0.75 • Loratidine <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Leventhroid 0.75 		
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	<ul style="list-style-type: none"> • Loratidine <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Levinthroid 0.75 (does not state dosage measurement) <ul style="list-style-type: none"> • Loratidine <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Levinthroid 0.75 <ul style="list-style-type: none"> • Loratidine <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Levinthroid 0.75 <ul style="list-style-type: none"> • Loratidine <p>Individual #8 January 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Levothyroxine .025mg <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Levothyroxine .025mg <p>February 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Levothyroxine .025mg <p>Medication Administration Records did not contain</p>		
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	<p>the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Levothyroxine .025mg <p>March 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Levothyroxine .025mg • Prednisolone 4ml (1 time daily) <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Levothyroxine .025mg <p>Individual #9 January 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Lovastatin 20 mg (1 time daily) <p>Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications:</p> <ul style="list-style-type: none"> • Lovastatin 20mg (1 time daily) <p>February 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Lovastatin 20 mg (1 time daily) <p>Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications:</p> <ul style="list-style-type: none"> • Lovastatin 20mg (1 time daily) <p>March 2010 Medication Administration Records did not contain the diagnosis for which the medication is</p>		
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	<p>prescribed:</p> <ul style="list-style-type: none"> • Lovastatin 20 mg (1 time daily) <p>Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications:</p> <ul style="list-style-type: none"> • Lovastatin 20mg (1 time daily) <p>Individual #10 January 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Singular 10mg (1 time daily) • Lopid 600mg (2 times daily) • Prilosec 30mg (1 time daily) • Lantis 30 Units <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Lantis 30 Units <p>February 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Singular 10mg (1 time daily) • Lopid 600mg (2 times daily) • Prilosec 30mg (1 time daily) • Lantis 30 Units <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Lantis 30 Units 		
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	<p>March 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Singular 10mg (1 time daily) • Lopid 600mg (2 times daily) • Prilosec 30mg (1 time daily) • Lantis 30 Units <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Lantis 30 Units <p>Individual #12 January 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Levothyroxin 150mcg <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Levothyroxin 150mcg <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxin 150mcg <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Levothyroxin 150mcg <p>February 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p>		
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	<ul style="list-style-type: none"> • Levothyroxin 150mcg <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Levothyroxin 150mcg <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxin 150mcg <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Levothyroxin 150mcg <p>March 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Levothyroxin 150mcg <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Levothyroxin 150mcg <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxin 150mcg <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Levothyroxin 150mcg <p>Individual #13 January 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p>		
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	<ul style="list-style-type: none"> • Nexium 40mg (1 time daily) • Lexapro 10mg (1 time daily) • Fexofenadine 180mg (1 time daily) • Lutera 28 (1 time daily) • Lipitor 10mg (1 time daily) • Metformin 500mg (3 times daily) • Amitiza 24 mcg (1 time daily) • Cimetidine 800mg (2 times daily) • Singular 10mg (1 time daily) • Citra-cal with Vitamin D (1 time daily) • Veramyst 27.5mcg (2 times daily) • Vitamin D 50,000 IU (1 time weekly) <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Citra-cal with Vitamin D (1 time daily) <p>February 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Nexium 40mg (1 time daily) • Lexapro 10mg (1 time daily) • Fexofenadine 180mg (1 time daily) • Lutera 28 (1 time daily) 		
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	<ul style="list-style-type: none"> • Lipitor 10mg (1 time daily) • Metformin 500mg (3 times daily) • Amitiza 24 mcg (1 time daily) • Cimetidine 800mg (2 times daily) • Singular 10mg (1 time daily) • Citra-cal with Vitamin D, Ca+ 630mg, Vitamin D 500 iu (1 time daily) • Veramyst 27.5mcg (2 times daily) • Vitamin D 50,000 IU (1 time weekly) <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Citra-cal with Vitamin D (1 time daily) <p>March 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Nexium 40mg (1 time daily) • Lexapro 10mg (1 time daily) • Fexofenadine 180mg (1 time daily) • Lutera 28 (1 time daily) • Lipitor 10mg (1 time daily) • Metformin 500mg (3 times daily) • Cimetidine 800mg (2 times daily) 		
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	<ul style="list-style-type: none"> • Singular 10mg (1 time daily) • Citra-cal with Vitamin D (1 time daily) • Veramyst 27.5mcg (2 times daily) • Vitamin D 50,000 IU (1 time weekly) • C-Phen DM (3 times daily) • Azithromycin 250mg (1 time daily) <p>Individual #14 January 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Cilostazol 100mg (2 times daily) <p>February 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Cilostazol 100mg (2 times daily) <p>March 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Cilostazol 100mg (2 times daily) <p>Individual #16 February 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Lactulose 10gm/15 (1 time daily) • Prevastatin 20mg (1 time daily) 		
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	<p>Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications:</p> <ul style="list-style-type: none"> • Lactulose 10gm/15 (1 time daily) • Prevastatin 20mg (1 time daily) <p>March 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Lactulose 10gm/15 (1 time daily) • Prevastatin 20mg (1 time daily) • Cephalexin 500mg (1 time every 8 hours) • Hydroco/ADAP 5/500 (1 time every 8 hours) <p>Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications:</p> <ul style="list-style-type: none"> • Lactulose 10gm/15 (1 time daily) <p>Individual #17 January 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Levothyroxine • Citrical (2 times daily) • Protonix • Vitorin (1 time daily) • Vitamin C (1 time daily) • Folic Acid (1 time daily) 		
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	<ul style="list-style-type: none"> • CQ10 (2 times daily) • Fish Oil (1 time daily) • Vitamin B12 (1 time daily) • Vitamin B12 (1 time monthly) <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Levothyroxine • Protonix <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxine • Citrical (2 times daily) • Protonix • Vitorin (1 time daily) • Vitamin C (1 time daily) • Folic Acid (1 time daily) • CQ10 (2 times daily) • Fish Oil (1 time daily) • Vitamin B12 (1 time daily) • Vitamin B12 (1 time monthly) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxine 		
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	<ul style="list-style-type: none"> • Citrical (2 times daily) • Protonix • Vitorin (1 time daily) • Vitamin C (1 time daily) • Folic Acid (1 time daily) • CQ10 (2 times daily) • Fish Oil (1 time daily) • Vitamin B12 (1 time daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Levothyroxine <ul style="list-style-type: none"> • Citrical (2 times daily) • Protonix • Vitorin (1 time daily) • Vitamin C (1 time daily) • Folic Acid (1 time daily) • CQ10 (2 times daily) • Fish Oil (1 time daily) • Vitamin B12 (1 time daily) • Vitamin B12 (1 time monthly) 		
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	<p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Levothyroxine • Citrical (2 times daily) • Protonix • Vitorin (1 time daily) • Vitamin C (1 time daily) • Folic Acid (1 time daily) • CQ10 (2 times daily) • Fish Oil (1 time daily) • Vitamin B12 (1 time daily) • Vitamin B12 (1 time monthly) <p>February 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Levothyroxine (1 time daily) • Citrical (2 times daily) • Protonix (1 time daily) • Vitorin (1 time daily) • Vitamin C (1 time daily) • Folic Acid (1 time daily) • CQ10 (1 time daily) 		
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	<ul style="list-style-type: none"> • Fish Oil (1 time daily) • Vitamin B12 (1 time daily) • Vitamin B12 (1 time monthly) <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxine (1 time daily) • Citrical (2 times daily) • Protonix (1 time daily) • Vitorin (1 time daily) • Vitamin C (1 time daily) • Folic Acid (1 time daily) • CQ10 (1 time daily) • Fish Oil (1 time daily) • Vitamin B12 (1 time daily) • Vitamin B12 (1 time monthly) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxine (1 time daily) • Citrical (2 times daily) • Protonix (1 time daily) • Vitorin (1 time daily) 		
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	<ul style="list-style-type: none"> • Vitamin C (1 time daily) • Folic Acid (1 time daily) • CQ10 (1 time daily) • Fish Oil (1 time daily) • Vitamin B12 (1 time daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Levothyroxine (1 time daily) • Citrical (2 times daily) • Protonix (1 time daily) • Vitorin (1 time daily) • Vitamin C (1 time daily) • Folic Acid (1 time daily) • CQ10 (1 time daily) • Fish Oil (1 time daily) • Vitamin B12 (1 time daily) • Vitamin B12 (1 time monthly) <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Levothyroxine (1 time daily) • Citrical (2 times daily) 		
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	<ul style="list-style-type: none"> • Protonix (1 time daily) • Vitorin (1 time daily) • Vitamin C (1 time daily) • Folic Acid (1 time daily) • CQ10 (1 time daily) • Fish Oil (1 time daily) • Vitamin B12 (1 time daily) • Vitamin B12 (1 time monthly) <p>March 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Levothyroxine (1 time daily) • Citrical (2 times daily) • Protonix (1 time daily) • Vitorin (1 time daily) • Vitamin C (1 time daily) • Folic Acid (1 time daily) • CQ10 (1 time daily) • Fish Oil (1 time daily) • Vitamin B12 (1 time daily) • Vitamin B12 (1 time monthly) 		
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	<p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxine (1 time daily) • Citrical (2 times daily) • Protonix (1 time daily) • Vitorin (1 time daily) • Vitamin C (1 time daily) • Folic Acid (1 time daily) • CQ10 (1 time daily) • Fish Oil (1 time daily) • Vitamin B12 (1 time daily) • Vitamin B12 (1 time monthly) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxine (1 time daily) • Citrical (2 times daily) • Protonix (1 time daily) • Vitorin (1 time daily) • Vitamin C (1 time daily) • Folic Acid (1 time daily) • CQ10 (1 time daily) • Fish Oil (1 time daily) 		
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	<ul style="list-style-type: none"> • Vitamin B12 (1 time daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Levothyroxine (1 time daily) • Citrical (2 times daily) • Protonix (1 time daily) • Vitorin (1 time daily) • Vitamin C (1 time daily) • Folic Acid (1 time daily) • CQ10 (1 time daily) • Fish Oil (1 time daily) • Vitamin B12 (1 time daily) • Vitamin B12 (1 time monthly) <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Levothyroxine (1 time daily) • Citrical (2 times daily) • Protonix (1 time daily) • Vitorin (1 time daily) • Vitamin C (1 time daily) • Folic Acid (1 time daily) 		
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	<ul style="list-style-type: none"> • CQ10 (1 time daily) • Fish Oil (1 time daily) • Vitamin B12 (1 time daily) • Vitamin B12 (1 time monthly) <p>Individual #18 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"> • Vitamin B Complex (1 time every other day) – Blank 1/2 & 8 (8:00 AM) <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Synthroid 0.50mg (1 time daily) • Premarin 0.625mg (1 time daily) • Provera (1 time daily) • Glucophage 500mg (2 times daily) • Glipizide 5mg (2 times daily) • Centrum Silver (1 time every other day) • Vitamin B Complex (1 time every other day) • Lisinopril 10mg (1 time daily) • Zocor 20mg (1 time daily) • Atarax 10mg (1 time daily) 		
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	<ul style="list-style-type: none"> • Fosamax 70mg (1 time weekly) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Synthroid 0.50mg (1 time daily) • Premarin 0.625mg (1 time daily) • Provera (1 time daily) • Glucophage 500mg (2 times daily) • Glipizide 5mg (2 times daily) • Centrum Silver (1 time every other day) • Vitamin B Complex (1 time every other day) • Lisinopril 10mg (1 time daily) • Zocor 20mg (1 time daily) • Atarax 10mg (1 time daily) • Fosamax 70mg (1 time weekly) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Synthroid 0.50mg (1 time daily) • Premarin 0.625mg (1 time daily) • Provera (1 time daily) • Glucophage 500mg (2 times daily) • Glipizide 5mg (2 times daily) 		
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	<ul style="list-style-type: none"> • Centrum Silver (1 time every other day) • Vitamin B Complex (1 time every other day) • Lisinopril 10mg (1 time daily) • Zocor 20mg (1 time daily) • Atarax 10mg (1 time daily) • Fosamax 70mg (1 time weekly) <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Provera (1 time daily) • Vitamin B Complex (1 time every other day) <p>February 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Synthroid 0.50mg (1 time daily) • Premarin 0.625mg (1 time daily) • Provera 10mg (1 time daily) • Glucophage 500mg (2 times daily) • Glipizide 5mg (2 times daily) • Centrum Silver (1 time every other day) • Vitamin B Complex (1 time every other day) • Lisinopril 10mg (1 time daily) • Zocor 20mg (1 time daily) 		
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	<ul style="list-style-type: none"> • Atarax 10mg (1 time daily) • Fosamax 70mg (1 time weekly) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Synthroid 0.50mg (1 time daily) • Premarin 0.625mg (1 time daily) • Provera 10mg (1 time daily) • Glucophage 500mg (2 times daily) • Glipizide 5mg (2 times daily) • Centrum Silver (1 time every other day) • Vitamin B Complex (1 time every other day) • Lisinopril 10mg (1 time daily) • Zocor 20mg (1 time daily) • Atarax 10mg (1 time daily) • Fosamax 70mg (1 time weekly) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Synthroid 0.50mg (1 time daily) • Premarin 0.625mg (1 time daily) • Provera 10mg (1 time daily) • Glucophage 500mg (2 times daily) 		
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	<ul style="list-style-type: none"> • Glipizide 5mg (2 times daily) • Centrum Silver (1 time every other day) • Vitamin B Complex (1 time every other day) • Lisinopril 10mg (1 time daily) • Zocor 20mg (1 time daily) • Atarax 10mg (1 time daily) • Fosamax 70mg (1 time weekly) <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Vitamin B Complex (1 time every other day) <p>March 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Synthroid 0.50mg (1 time daily) • Premarin 0.625mg (1 time daily) • Provera 10mg (1 time daily) • Glucophage 500mg (2 times daily) • Glipizide 5mg (2 times daily) • Centrum Silver (1 time every other day) • Vitamin B Complex (1 time every other day) • Lisinopril 10mg (1 time daily) 		
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	<ul style="list-style-type: none"> • Zocor 20mg (1 time daily) • Atarax 10mg (1 time daily) • Fosamax 70mg (1 time weekly) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Synthroid 0.50mg (1 time daily) • Premarin 0.625mg (1 time daily) • Provera 10mg (1 time daily) • Glucophage 500mg (2 times daily) • Glipizide 5mg (2 times daily) • Centrum Silver (1 time every other day) • Vitamin B Complex (1 time every other day) • Lisinopril 10mg (1 time daily) • Zocor 20mg (1 time daily) • Atarax 10mg (1 time daily) • Fosamax 70mg (1 time weekly) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Synthroid 0.50mg (1 time daily) • Premarin 0.625mg (1 time daily) • Provera 10mg (1 time daily) 		
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	<ul style="list-style-type: none"> • Glucophage 500mg (2 times daily) • Glipizide 5mg (2 times daily) • Centrum Silver (1 time every other day) • Vitamin B Complex (1 time every other day) • Lisinopril 10mg (1 time daily) • Zocor 20mg (1 time daily) • Atarax 10mg (1 time daily) • Fosamax 70mg (1 time weekly) <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Vitamin B Complex (1 time every other day) <p>Individual #19 January 2010</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg • Zantac 150mg • Zocor 20mg <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg 		
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	<ul style="list-style-type: none"> • Zantac 150mg • Zocor 20mg <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg • Zantac 150mg • Zocor 20mg <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg • Zantac 150mg • Zocor 20mg <p>Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg • Zantac 150mg • Zocor 20mg <p>February 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p>		
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	<ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg • Zantac 150mg • Zocor 20mg <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg • Zantac 150mg • Zocor 20mg <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg • Zantac 150mg • Zocor 20mg <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg • Zantac 150mg • Zocor 20mg 		
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	<p>Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg • Zantac 150mg • Zocor 20mg <p>March 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg • Zantac 150mg • Zocor 20mg <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg • Zantac 150mg • Zocor 20mg <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg 		
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	<ul style="list-style-type: none"> • Zantac 150mg • Zocor 20mg <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg • Zantac 150mg • Zocor 20mg <p>Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg • Zantac 150mg • Zocor 20mg <p>Medication Administration Records did not contain the Name of the Individual for which the following medications are prescribed:</p> <ul style="list-style-type: none"> • Allupurinol 150mg • Synthroid 12mg • Zantac 150mg • Zocor 20mg <p>Individual #20 January 2010 During on-site survey Medication Administration Records were requested for month of January</p>		
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	<p>2010. As of 6/1/2010, Medication Administration Records for January had not been provided. As Indicated by the Medication Administration Assessment Tool 3/10/2010, Individual #20 meets the criteria for Assistance with Medication Delivery by Staff.</p> <p>February 2010 During on-site survey Medication Administration Records were requested for month of February 2010. As of 6/1/2010, Medication Administration Records for February had not been provided. As indicated by the Medication Administration Assessment Tool 3/10/2010, Individual #20 meets the criteria for Assistance with Medication Delivery by Staff.</p> <p>March 2010 During on-site survey Medication Administration Records were requested for month March 2010. As of 6/1/2010, Medication Administration Records for March had not been provided. As indicated by the Medication Administration Assessment Tool 3/10/2010, Individual #20 meets the criteria for Assistance with Medication Delivery by Staff.</p>		
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Tag # 1A09 Medication Delivery - PRN Medication	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <ul style="list-style-type: none"> (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or 	<p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 8 of 20 Individuals.</p> <p>Individual #1 January 2010</p> <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"> • Glucophage 500mg (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Glucophage 500mg (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications</p> <ul style="list-style-type: none"> • Glucophage 500mg (PRN) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Glucophage 500mg (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Glucophage 500mg – PRN – 1/3, 9 & 22 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Glucophage 500mg – PRN – 1/3, 9 & 22 (given 1 time) 		

<p>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>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; 	<p>February 2010</p> <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"> • Glucophage 500mg (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Glucophage 500mg (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications</p> <ul style="list-style-type: none"> • Glucophage 500mg (PRN) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Glucophage 500mg (PRN) <p>March 2010</p> <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"> • Glucophage 500mg (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Glucophage 500mg (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications</p> <ul style="list-style-type: none"> • Glucophage 500mg (PRN) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p>		
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<p>(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.</p> <p>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.</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"> ➤ 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. <p>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</p>	<ul style="list-style-type: none"> • Glucophage 500mg (PRN) <p>Individual #2 January 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Albuterol 2mg (PRN) • Ibuprofen 800mg (PRN) • Proctosol 2.5% (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Albuterol 2mg (PRN) • Ibuprofen 800mg (PRN) • Proctosol 2.5% (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Albuterol 2mg (PRN) • Ibuprofen 800mg (PRN) • Proctosol 2.5% (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Albuterol 2mg – PRN – 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) • Ibuprofen 800mg – PRN – 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 		
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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

times)

- Proctosol 2.5% – PRN – 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times)

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:

- Albuterol 2mg – PRN – 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times)

- Ibuprofen 800mg – PRN – 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times)

- Proctosol 2.5% – PRN – 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times)

Medication Administration Records did not contain the route of administration for the following medications:

- Albuterol 2mg (PRN)
- Ibuprofen 800mg (PRN)
- Proctosol 2.5% (PRN)

Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:

- Albuterol 2mg (PRN)
- Ibuprofen 800mg (PRN)
- Proctosol 2.5% (PRN)

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.).

February 2010

Medication Administration Records did not contain the exact amount to be used in a 24 hour period:

- Albuterol 2mg (PRN)
- Ibuprofen 800mg (PRN)
- Proctosol 2.5% (PRN)

Medication Administration Records did not contain the circumstance for which the medication is to be used:

- Albuterol 2mg (PRN)
- Ibuprofen 800mg (PRN)
- Proctosol 2.5% (PRN)

Medication Administration Records did not contain the route of administration for the following medications:

- Albuterol 2mg (PRN)
- Ibuprofen 800mg (PRN)
- Proctosol 2.5% (PRN)

No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:

- Albuterol 2mg – PRN – 2/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 & 28 (given 2 times)
- Ibuprofen 800mg – PRN – 2/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 & 28 (given 2 times)
- Proctosol 2.5% – PRN – 2/1, 2, 3, 4, 5, 6, 7, 8,

	<p>9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 & 28 (given 2 times)</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Albuterol 2mg – PRN – 2/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 & 28 (given 2 times) • Ibuprofen 800mg – PRN – 2/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 & 28 (given 2 times) • Proctosol 2.5% – PRN – 2/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 & 28 (given 2 times) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Albuterol 2mg (PRN) • Ibuprofen 800mg (PRN) • Proctosol 2.5% (PRN) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Albuterol 2mg (PRN) • Ibuprofen 800mg (PRN) • Proctosol 2.5% (PRN) <p>March 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Albuterol 2mg (PRN) 		
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	<ul style="list-style-type: none"> •Ibuprofen 800mg (PRN) •Proctosol 2.5% (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> •Albuterol 2mg (PRN) <ul style="list-style-type: none"> •Ibuprofen 800mg (PRN) •Proctosol 2.5% (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> •Albuterol 2mg (PRN) <ul style="list-style-type: none"> •Ibuprofen 800mg (PRN) •Proctosol 2.5% (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> •Albuterol 2mg – PRN – 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 3 times) •Ibuprofen 800mg – PRN – 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) •Proctosol 2.5% – PRN – 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) <p>No Effectiveness was noted on the Medication</p>		
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	<p>Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Albuterol 2mg – PRN – 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 3 times) • Ibuprofen 800mg – PRN – 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) • Proctosol 2.5% – PRN – 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Albuterol 2mg (PRN) • Ibuprofen 800mg (PRN) • Proctosol 2.5% (PRN) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Albuterol 2mg (PRN) • Ibuprofen 800mg (PRN) • Proctosol 2.5% (PRN) <p>Individual #3 January 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Day Quill (PRN) 		
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	<ul style="list-style-type: none"> •Ny Quill (PRN) •Tylenol 650mg (PRN) •Woltaren 1% (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> •Day Quill (PRN) •Ny Quill (PRN) •Tylenol 650mg (PRN) •Woltaren 1% (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> •Day Quill (PRN) •Ny Quill (PRN) •Tylenol 650mg (PRN) •Woltaren 1% (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> •Day Quill – PRN – 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) •Ny Quill – PRN – 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 time) •Tylenol 650mg – PRN – 1/1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 		
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	<p>23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 3 times); 1/8 (given 2 times)</p> <ul style="list-style-type: none"> •Woltaren 1% - PRN – 1/ 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> •Day Quill – PRN – 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) •Ny Quill – PRN – 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 time) •Tylenol 650mg – PRN – 1/1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 3 times); 1/8 (given 2 times) •Woltaren 1% - PRN – 1/ 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 time) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> •Day Quill (PRN) •Ny Quill (PRN) •Tylenol 650mg (PRN) •Woltaren 1% (PRN) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p>		
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	<ul style="list-style-type: none"> •Day Quill (PRN) •Ny Quill (PRN) •Tylenol 650mg (PRN) •Woltaren 1% (PRN) <p>Medication Administration Records did not contain the dose of the medication which is to be given:</p> <ul style="list-style-type: none"> •Day Quill (PRN) •Ny Quill (PRN) •Woltaren 1% (PRN) <p>February 2010</p> <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"> •Tylenol 650mg (PRN) •Woltaren 1% (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> •Tylenol 650mg (PRN) •Woltaren 1% (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> •Tylenol 650mg (PRN) •Woltaren 1% (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the</p>		
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	<p>following PRN medication:</p> <ul style="list-style-type: none"> • Tylenol 650mg – PRN – 2/1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 & 28 (given 3 times); 1/8 (given 2 times) • Woltaren 1% - PRN – 2/ 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 & 28 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Tylenol 650mg – PRN – 2/1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 & 28 (given 3 times) • Woltaren 1% - PRN – 2/ 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 & 28 (given 1 time) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Tylenol 650mg (PRN) • Woltaren 1% (PRN) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Tylenol 650mg (PRN) • Woltaren 1% (PRN) <p>Medication Administration Records did not contain the dose of the medication which is to be given:</p> <ul style="list-style-type: none"> • Woltaren 1% (PRN) <p>March 2010</p>		
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	<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"> • Day Quill (PRN) • Ny Quill (PRN) • Tylenol 650mg (PRN) • Woltaren 1% (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Day Quill (PRN) • Ny Quill (PRN) • Tylenol 650mg (PRN) • Woltaren 1% (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Day Quill (PRN) • Ny Quill (PRN) • Tylenol 650mg (PRN) • Woltaren 1% (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Day Quill – PRN – 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) • Ny Quill – PRN – 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 		
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	<p>11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 time)</p> <ul style="list-style-type: none"> • Tylenol 650mg – PRN – 3/1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 3 times); 1/8 (given 2 times) • Woltaren 1% - PRN – 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Day Quill – PRN – 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 2 times) • Ny Quill – PRN – 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 time) • Tylenol 650mg – PRN – 3/1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 3 times); 1/8 (given 2 times) • Woltaren 1% - PRN – 3/ 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (given 1 time) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Day Quill (PRN) • Ny Quill (PRN) • Tylenol 650mg (PRN) 		
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	<ul style="list-style-type: none"> •Woltaren 1% (PRN) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> •Day Quill (PRN) •Ny Quill (PRN) •Tylenol 650mg (PRN) •Woltaren 1% (PRN) <p>Medication Administration Records did not contain the dose of the medication which is to be given:</p> <ul style="list-style-type: none"> •Day Quill (PRN) •Ny Quill (PRN) •Woltaren 1% (PRN) <p>Individual #7 January 2010</p> <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"> •HFA Inhaler (PRN) •Ibuprofen 80mg (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> •HFA Inhaler (PRN) •Ibuprofen 80mg (PRN) <p>Individual #8 March 2010</p> <p>Medication Administration Records did not</p>		
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	<p>contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Proair Inhaler (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Proair Inhaler – PRN – 3/26 & 29 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Proair Inhaler – PRN – 3/26 & 29 (given 1 time) <p>Individual #9 January 2010</p> <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"> • Loratadine (PRN) • Aspirin 325mg <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Aspirin 325mg <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Loratadine (PRN) • Aspirin 325mg <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Loratadine – PRN – 1/20, 21 & 22 (given 1 time) • Aspirin 325mg – 1/22 & 23 (given 1 time) 		
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	<p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Loratadine – PRN – 1/20, 21 & 22 (given 1 time) • Aspirin 325mg – 1/22 & 23 (given 1 time) <p>Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard:</p> <ul style="list-style-type: none"> • Aspirin 325mg <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Loratadine (PRN) • Aspirin 325mg <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Loratadine (PRN) • Aspirin 325mg <p>February 2010</p> <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Loratadine (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Loratadine (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the</p>		
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	<p>following PRN medication:</p> <ul style="list-style-type: none"> • Loratadine – PRN – 2/10 & 11 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Loratadine – PRN – 2/10 & 11 (given 1 time) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Loratadine (PRN) <p>March 2010</p> <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"> • Pepto Bismol (PRN) • Tylenol 500mg (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Pepto Bismol (PRN) • Tylenol 500mg (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Pepto Bismol (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Pepto Bismol – PRN – 3/12 & 13 (given 2 times) • Tylenol 500mg – 3/2, 3, 4 & 5 (given 1 time) <p>No Effectiveness was noted on the Medication</p>		
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	<p>Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Pepto Bismol – PRN – 3/12 & 13 (given 2 times) • Tylenol 500mg – 3/2, 3, 4 & 5 (given 1 time) <p>Individual #10 January 2010</p> <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"> • Ibuprofen 800mg (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Ibuprofen 800mg (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Ibuprofen 800mg – PRN – 1/11, 12, 13 & 14 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Ibuprofen 800mg – PRN – 1/11, 12, 13 & 14 (given 1 time) <p>February 2010</p> <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"> • Ibuprofen 800mg (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Ibuprofen 800mg (PRN) 		
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	<p>March 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: <ul style="list-style-type: none"> • Ibuprofen 800mg (PRN) Medication Administration Records did not contain the circumstance for which the medication is to be used: <ul style="list-style-type: none"> • Ibuprofen 800mg (PRN) Individual #11 January 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: <ul style="list-style-type: none"> • Acetaminophen 500mg/15ml (PRN) • Zyrtec 10mg (PRN) Medication Administration Records did not contain the circumstance for which the medication is to be used: <ul style="list-style-type: none"> • Acetaminophen 500mg/15ml (PRN) • Zyrtec 10mg (PRN) Medication Administration Records did not contain the route of administration for the following medications: <ul style="list-style-type: none"> • Zyrtec 10mg (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: <ul style="list-style-type: none"> • Acetaminophen 500mg/15ml – PRN – 1/7, 8, 9 & 10 (given 1 time) • Zyrtec 10mg – PRN – 1/7, 8, 9, 10, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 1 time) </p>		
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	<p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Acetaminophen 500mg/15ml – PRN – 1/7, 8, 9 & 10 (given 1 time) • Zyrtec 10mg – PRN – 1/7, 8, 9, 10, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 1 time) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Zyrtec 10mg (PRN) <p>February 2010</p> <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"> • Benadryl 12.5mg/5ml • Zyrtec 5mg/5ml (PRN) • Tylenol 500mg/15ml <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Benadryl 12.5mg/5ml • Zyrtec 5mg/5ml (PRN) • Tylenol 500mg/15ml <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Benadryl 12.5mg/5ml • Tylenol 500mg/15ml 		
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	<p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Tylenol 500mg/15ml – 2/1 & 2 (given 2 times); 2/3 & 4 (given 1 time) • Zyrtec 5mg/5ml – PRN – 2/1, 2, 3, 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 24, 25, 26, 27 & 28 (given 1 time) • Benadryl 12.5mg/5ml – 2/9, 10 & 23 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Tylenol 500mg/15ml – 2/1 & 2 (given 2 times); 2/3 & 4 (given 1 time) • Zyrtec 5mg/5ml – PRN – 2/1, 2, 3, 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 24, 25, 26, 27 & 28 (given 1 time) • Benadryl 12.5mg/5ml – 2/9, 10 & 23 (given 1 time) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Benadryl 12.5mg/5ml • Tylenol 500mg/15ml <p>Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard:</p> <ul style="list-style-type: none"> • Benadryl 12.5mg/5ml • Tylenol 500mg/15ml 		
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	<p>March 2010</p> <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"> • Benadryl 12.5mg/5ml • Allergy Shot 40mg • Acetaminophen 500mg/15ml <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Benadryl 12.5mg/5ml • Acetaminophen 500mg/15ml <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Benadryl 12.5mg/5ml <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Acetaminophen 500mg/15ml – 3/2, 3 & 4 (given 2 times); 3/5 (given 1 time) • Benadryl 12.5mg/5ml – 3/1, 2, 3, 4, 6, 7, 8, 9 & 10 (given 1 time) • Allergy Shot 40mg – 3/11 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Acetaminophen 500mg/15ml – 3/2, 3 & 4 (given 2 times); 3/5 (given 1 time) • Benadryl 12.5mg/5ml – 3/1, 2, 3, 4, 6, 7, 8, 9 & 		
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	<p>10 (given 1 time)</p> <ul style="list-style-type: none">• Allergy Shot 40mg – 3/11 (given 1 time) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none">• Benadryl 12.5mg/5ml <p>Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard:</p> <ul style="list-style-type: none">• Benadryl 12.5mg/5ml • Allergy Shot 40mg		
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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>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>G. Transportation: 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"> (1) Drivers' requirements, (2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions, (3) Vehicle maintenance and safety inspections, (4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures, (5) Emergency Plans, including vehicle evacuation techniques, (6) Documentation, and (7) Accident Procedures. <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy 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 85 of 164 Direct Service Personnel.</p> <p>No documented evidence was found of the following required training:</p> <ul style="list-style-type: none"> • Transportation (DSP #41, 43, 44, 45, 48, 49,51, 54, 55, 59, 60, 62, 63, 66, 67, 69, 75, 77, 81, 84, 86, 90, 91, 92, 93, 97, 101, 102, 105, 109, 111, 112,113, 114, 116, 117, 118, 119, 120, 128, 136, 137, 141, 144, 145, 150, 151, 159, 160, 162, 163, 166, 167, 168, 170, 171, 172, 174, 175, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201 & 202) <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 #42 stated, "No. I trained myself"</p> <p>DSP#93 stated, "No, training from Agency."</p> <p>DSP#97 stated, "Not from Agency."</p> <p>DSP#154 stated, "No, not from Agency."</p> <p>DSP#156 stated, "No, not at any agency."</p> <p>DSP#165 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 # 1A15 Nurse Availability	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>NEW MEXICO NURSING PRACTICE ACT CHAPTER 61, ARTICLE 3</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 1 of 20 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"> • DSP #217 stated, "I don't know." 		

Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</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"> (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. <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 complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 8 of 20 individual</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Quarterly Nursing Review of HCP/Crisis Plans: <ul style="list-style-type: none"> ◦ None found for 10/2009 - 3/2010 (#1) ◦ None found for 4/2009 - 2/2010 (#2) ◦ None found for 9/2009 - 2/2010 (#13) ◦ None found for 4/2009 - 3/2010 (#17) • Health Care Plans <ul style="list-style-type: none"> • Gastrointestinal/Reflux <ul style="list-style-type: none"> ◦ Individual #13 - As indicated by the IST section of the ISP the individual is required to have a plan. ◦ Individual #17 - As indicated by the IST section of the ISP the individual is required to have a plan. • Insulin Resistance – Rx for Metformin <ul style="list-style-type: none"> ◦ Individual #13 - As indicated by the IST section of ISP the individual is required to have a plan. • Respiratory <ul style="list-style-type: none"> ◦ Individual #17 - As indicated by the IST section of ISP the individual is required to have a plan. • Hypothyroid <ul style="list-style-type: none"> ◦ Individual #17 - As indicated by the IST section of ISP the individual is required to have a plan. 	

<p>agency nurse must be available to assist the caregiver upon request.</p> <p>(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.</p> <p>(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).</p> <p>(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 <i>subjective</i> information including the individual complaints, signs and symptoms noted by staff, family members or other team members; <i>objective</i> information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); <i>assessment</i> of the clinical status, and <i>plan</i> of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.</p> <p>(2) Health related plans</p> <p>(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or</p>	<ul style="list-style-type: none"> • Pacemaker <ul style="list-style-type: none"> ◦ Individual #17 - As indicated by the IST section of the ISP the individual is required to have a plan. • Increased Cholesterol <ul style="list-style-type: none"> ◦ Individual #17 - As indicated by the IST section of the ISP the individual is required to have a plan. • Hip Precaution <ul style="list-style-type: none"> ◦ Individual #17 - As indicated by the IST section of the ISP the individual is required to have a plan. • Crisis Plans <ul style="list-style-type: none"> • Diabetes <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan. ◦ Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. • Allergies <ul style="list-style-type: none"> ◦ Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. • Gastrointestinal/Reflux <ul style="list-style-type: none"> ◦ Individual #13 - As indicated by the IST section of ISP the individual is required to have a plan. ◦ Individual #19 - As indicated by the IST section of ISP the individual is required to have a plan. • Asthma <ul style="list-style-type: none"> ◦ Individual #13 - As indicated by the IST section of ISP the individual is required to have a plan. 		
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<p>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>(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):</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 members or other team members, and other</p>			
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interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan.

(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.

(e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings.

(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.

(g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author.

(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.

(4) General Nursing Documentation

(a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person.

(b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: F	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>C. Orientation and Training Requirements: 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> <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>(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.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 137 of 163 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"> • Pre- Service (DSP #55, 182, 184, 186, 187, 188, 189, 191, 192, 193, 194, 195, 197, 198, 199, 200, 201 & 202) • Basic Health/Orientation (DSP #55, 184, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201 & 202) • Person-Centered Planning (1-Day) (DSP #182, 186, 187, 188, 189, 191, 192, 193, 194, 195, 199, 200, 201 & 202) • First Aid (DSP #41, 42, 44, 45, 50, 53, 54, 56, 59, 63, 67, 74, 75, 77, 81, 82, 87, 89, 90, 91, 92, 93, 94, 98, 102, 103, 104, 105, 107, 110, 114, 115, 116, 117, 119, 123, 125, 126, 130, 131, 133, 134, 137, 138, 139, 140, 142, 143, 147, 148, 149, 151, 156, 157, 160, 161, 162, 163, 164, 165, 167, 168, 169, 171, 173, 175, 176, 178, 179, 180, 181, 182, 183, 187, 188, 189, 190, 191, 192, 194, 195, 199, 200 & 206) • CPR (DSP #42, 44, 45, 48, 49, 50, 52, 53, 54, 57, 58, 59, 62, 63, 66, 67, 70, 71, 74, 75, 77, 81, 82, 83, 87, 89, 90, 91, 92, 93, 95, 96, 104, 105, 107, 110, 112, 114, 115, 116, 117, 118, 119, 120, 123, 124, 125, 126, 128, 131, 133, 134, 135, 137, 138, 139, 140, 142, 143, 148, 150, 151, 155, 156, 157, 160, 161, 162, 163, 164, 165, 167, 168, 169, 170, 171, 173, 174, 175, 176, 178, 181, 182, 183, 187, 188, 189, 190, 191, 	

<p>known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p> <p>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.</p> <p>E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.</p> <p>F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.</p> <p>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.</p> <p>H. Staff shall complete and maintain certification in a DDS-approved medication course in accordance with the DDS Medication Delivery Policy M-001.</p> <p>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.</p>	<p>199, 200, 202, 204, 205, 206, 208 & 210)</p> <ul style="list-style-type: none"> • Assisting With Medication Delivery (DSP #41, 42, 45, 48, 49, 53, 55, 56, 58, 59, 61, 62, 65, 66, 70, 71, 74, 75, 76, 77, 78, 79, 82, 83, 85, 87, 89, 90, 92, 94, 95, 96, 102, 105, 107, 108, 109, 113, 114, 115, 116, 117, 121, 123, 124, 125, 131, 136, 137, 141, 144, 150, 151, 152, 158, 159, 162, 166, 171, 173, 174, 175, 177, 178, 180, 181, 182, 183, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 199, 200, 201, 204, 206, 208 & 210) • Rights & Advocacy (DSP #55, 89, 117, 186, 187, 188, 189, 190, 195, 199, 200 & 202) • Level 1 Health (DSP #55, 117, 186, 187, 188, 189, 190, 195, 199, 200 & 202) • Teaching & Support Strategies (DSP #55, 117, 141, 186, 187, 188, 189, 190, 195, 199, 200 & 202) • Positive Behavior Supports Strategies (DSP #55, 117, 141, 186, 187, 188, 189, 195, 199, 200 & 202) • Participatory Communication & Choice Making (DSP #55, 117, 186, 187, 188, 189, 190, 195, 199, 200 & 202) 		
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Tag # 1A22 Staff Competence	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>F. Qualifications for Direct Service Personnel: The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</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</p>	<p>Based on interview, the Agency failed to ensure that training competencies were met for 8 of 18 Direct Service Personnel.</p> <p>When DSP were asked if they received training on the Individual's ISP and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #89 stated, "I didn't have training; I have one, (but) I haven't read it." (Individual #20) <p>When DSP were asked if they received training on the Individual's Speech Therapy Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #170 stated, "I have nothing to do with that." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #12) • DSP #170 stated, "They don't tell what they're doing." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #15) <p>When DSP were asked if they received training on the Individual's Occupational Therapy Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #170 stated, "No training." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #12) • DSP #170 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #15) 	

<p>qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and</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> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent</p>	<p>When DSP were asked if they received training on the Individual’s Physical Therapy Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #170 stated, “No training.” According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan. (Individual #15) <p>When DSP were asked if the Individual had any Health Care Plans and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #154 stated, “No she gets an allergy shot and uses Singular.” As indicated by the Agency file, the Individual has a Health Care Plan for Asthma. <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"> • DSP #42 stated, “She has one for depression not for anything else.” As indicated by the Agency file, the Individual has a Crisis Plan for Respiratory. • DSP #89 stated, “I don’t know.” As indicated by the Agency file, the Individual has a Crisis Plan for Seizures. (Individual #20) <p>When DSP were asked, what are the steps did they need to take when there is a medication error, the following was reported:</p> <ul style="list-style-type: none"> • DSP #137 stated, “I don’t remember.” (Individual #18) 		
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and qualified staff.

When DSP were asked what they do if there is low blood sugar, the following was reported:

- DSP #156 stated, "I don't know; he doesn't have that." The individual has a diagnosis of Diabetes. (Individual #5)

When DSP were asked to describe the signs and symptoms of an Allergic Reaction to food, the following was reported:

- DSP #156 stated, "I don't know the reaction; he doesn't have anything like that." (Individual #5)

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D	
<p>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</p> <p>NMAC 7.1.9.9 - CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</p> <p>NMAC 7.1.9.11 - DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: A. homicide; B. trafficking, or trafficking in controlled substances; C. kidnapping, false imprisonment, aggravated assault or aggravated battery; D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; E. crimes involving adult abuse, neglect or financial exploitation; F. crimes involving child abuse or neglect; G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or</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 22 of 172 Agency Personnel.</p> <p>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</p> <ul style="list-style-type: none"> • #45 – Date of hire 9/7/2007 • #90 – Date of hire 1/17/2008 • #91 – Date of hire 8/24/05 • #92 – Date of hire 8/1/2007 • #102 – Date of hire 9/29/2009 • #114 – Date of hire 1/20/2010 • #137 – Date of hire 9/7/2008 • #141 – Date of hire 7/16/2009 • #145 – Date of hire 4/5/2010 • #159 – Date of hire 6/1/2009 • #171 – Date of hire not provided • #183 – Date of hire 8/10/2006 • #186 – Date of hire 6/15/2007 • #194 – Date of hire 8/3/2009 	

H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.

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.

- #195 – Date of hire 1/14/2009
- #197 – Date of hire 3/15/2010
- #199 – Date of hire 5/19/2009
- #203 – Date of hire 8/26/2009
- #209 – Date of hire 8/4/2008
- #213 – Date of hire 7/8/2008
- #214 – Date of hire 2/9/2010
- #215 – Date of hire 2/18/ 2010

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E		
<p>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse,</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 30 of 172 Agency Personnel.</p> <p>The following Agency personnel records contained no evidence of the Employee Abuse Registry being completed:</p> <ul style="list-style-type: none"> • #90 – Date of hire 1/17/2008 • #105 – Date of hire 6/22/2009 • #121 – Date of hire 7/4/2006 • #187 – Date of hire 4/17/2009 • #191 – Date of hire 10/9/2009 • #194 – Date of hire 8/3/2009 • #197 – Date of hire 3/15/2010 • #203 – Date of hire 8/26/2009 • #209 – Date of hire 8/4/2008 • #213 – Date of hire 7/8/2008 • #214 – Date of hire 2/9/2010 • #215 – Date of hire 2/18/2010 <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"> • #41 – Date of hire 12/1/2007. Completed 		

<p>neglect or exploitation.</p> <p>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.</p> <p>F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>Chapter 1.IV. General Provider Requirements.</p> <p>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.</p>	<p>12/12/2007.</p> <ul style="list-style-type: none"> • #43 – Date of hire 8/15/2008. Completed 8/27/2008. • #44 – Date of hire 11/26/2008. Completed 12/22/2008. • #51 – Date of hire 2/15/2010. Completed 3/11/2010. • #59 – Date of hire 5/11/2010. Completed 5/18/2010. • #67 – Date of hire 8/17/2009. Completed 10/5/2009. • #84 – Date of hire 10/13/2009. Completed 12/29/2009. • #86 – Date of hire 5/17/2009. Completed 6/9/2009. • #101 – Date of hire 8/17/2008. Completed 10/20/2008. • #114 – Date of hire 1/20/2010. Completed 3/11/2010. • #137 – Date of hire 9/7/2008. Completed 5/26/2010. • #142 – Date of hire 9/15/2007. Completed 4/9/2008. • #145 – Date of hire 4/5/2010. Completed 5/26/2010. • #184 – Date of hire 4/18/2010. Completed 5/26/2010. 		
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| | <ul style="list-style-type: none">• #190 – Date of hire 8/4/2008. Completed 8/18/2008.• #196 – Date of hire 2/18/2010. Completed 5/26/2010.• #200 – Date of hire 3/3/2009. Completed 3/25/2009.• #202 – Date of hire 8/28/2008. Completed 10/22/2008. | | |
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Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: E		
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</p> <p>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</p> <p>II. POLICY STATEMENTS:</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 54 of 172 Agency Personnel.</p> <ul style="list-style-type: none"> Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#44, 45, 53, 55, 61, 73, 74, 77, 78, 83, 90, 94, 104, 105, 113, 114, 116, 117, 119, 125, 130, 131, 132, 133, 135, 139, 141, 144, 145, 157, 167, 168, 174, 176, 182, 183, 186, 187, 189, 194, 195, 197, 199, 200, 202, 203, 205, 208, 209, 210, 211, 212, 213 & 214) 		

Tag # 1A28 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: D		
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>E. Consumer and Guardian Orientation Packet: Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.</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 20 individuals.</p> <ul style="list-style-type: none"> • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#13) 		

Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: D		
<p>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:</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>Long Term Services Division Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003 - IV. POLICY STATEMENT -</p> <p>Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the</p>	<p>Based on record review and interview, the Agency failed to ensure the rights of Individuals was not restricted or limited for 1 of 20 Individuals. (Individual #5)</p> <p>A review of Agency Individual files indicated 1 of 20 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"> • Locking the Kitchen - (Individual #5) <p>When #218 was asked if the Agency had documentation of Human Rights approval, the following was reported,</p> <p>#218 stated, "We don't have it."</p>		

<p>implementation of certain Behavior Support Plans.</p> <p>Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:</p> <ul style="list-style-type: none"> • Aversive Intervention Prohibitions • Psychotropic Medications Use • Behavioral Support Service Provision. <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006</p> <p>B. 1. e. If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms</p>			
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in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: E		
<p>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<p>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 7 of 20 individuals.</p> <p>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #16</p> <ul style="list-style-type: none"> • None found for 1/2010 <p>Independent Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #20</p> <ul style="list-style-type: none"> • No Outcomes/Action Plans or DDSD exemption/decision justification found for Independent Living Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver." <p>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #12</p> <ul style="list-style-type: none"> • No Outcomes/Action Plans or DDSD exemption/decision justification found for Adult Habilitation Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities 		

	<p>Medicaid waiver.”</p> <p>Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #3</p> <ul style="list-style-type: none"> • None found for 1/2010 – 4/2010 <p>Individual #4</p> <ul style="list-style-type: none"> • None found for 1/2020 – 3/2010 <p>Individual #5</p> <ul style="list-style-type: none"> • None found for 1/2020 – 3/2010 <p>Individual #18</p> <ul style="list-style-type: none"> • No Outcomes/Action Plans or DDSD exemption found/decision justification found for Community Access Services. As indicated by NMAC 7.26.5.14 “Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.” 		
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Tag # 1A36 SC Training	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</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 5 of 14 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"> • Pre-Service Manual (SC #214 & 216) • Person Centered Planning (2-Day) (SC #214) • Promoting Effective Teamwork (SC #203 & 214) • Advocacy Strategies (SC #207) • ISP Critique (SC #209) • Level 1 Health (SC #207) 		

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(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.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 -</p> <p>II. POLICY STATEMENTS:</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 individual service plan (ISP) of each individual served.</p>	<p>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 104 of 172 Agency Personnel.</p> <p>Review of personnel records found no evidence of the following:</p> <ul style="list-style-type: none"> Individual Specific Training (#41, 47, 48, 49, 51, 54, 55, 56, 59, 60, 61,63, 66, 69, 70, 71, 73, 74, 75, 77, 81, 87, 88, 89, 90, 91, 92, 94, 95,96, 98, 103, 105, 107, 113, 116, 117, 118, 119, 120, 123, 125, 128, 131, 134, 135, 136, 138, 139, 141, 142, 143, 145, 147, 148, 149, 151, 152, 155, 156, 158, 162, 163, 164, 165, 166, 167, 169, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 186, 187, 189, 191, 193, 194, 195, 196, 197, 198, 199, 200, 202, 206, 207, 210, 211, 212, 213, 214, 215 & 216) 		

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS</p> <p>E. Provider Agency Reporting Requirements: All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation:</p> <ol style="list-style-type: none"> (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: <ol style="list-style-type: none"> (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD. 	<p>Based on record review, the Agency failed to complete quarterly reports as required for 4 of 7 individuals receiving Community Inclusion services.</p> <p>Community Access Quarterly Reports</p> <ul style="list-style-type: none"> • Individual #3 - None found for 8/2009 - 4/2010 • Individual #4 - None found for 1/2010 - 3/2010 • Individual #5 - None found for 1/2010 - 3/2010 • Individual #18 - None found for 9/2009 - 2/2010 <p>Note: Agency completes monthly reports.</p>		

Tag # 5I36 CA Reimbursement	Scope and Severity Rating: B	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</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>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 XI. COMMUNITY ACCESS</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 3 of 7 individuals.</p> <p>Individual #7 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 112 units of Community Access from 1/1/2010 through 1/15/2010. Documentation provided accounted for 72 units per time in/time out. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress note (2 service intervals on documented on 1 page with 1 staff signature). ◦ A description of what occurred during the encounter or service interval to justify billing. ◦ The Agency billed 132 units of Community Access from 1/16/2010 through 1/31/2010. No documentation provided to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 112 units of Community Access from 2/1/2010 through 2/15/2010. Documentation provided accounted for 40 units in February per time in/time out. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes (2 service intervals on documented on 1 page with 1 staff signature). 	

SERVICES REQUIREMENTS

G. Reimbursement

(1) Billable Unit: A billable unit is defined as one-quarter hour of service.

(2) Billable Activities: The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions:

- (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan;
- (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and
- (c) Non face-to-face hours do not exceed 10% of the monthly billable hours.

(3) Non-Billable Activities: Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include:

- (a) Time and expense for training service personnel;
- (b) Supervision of agency staff;
- (c) Service documentation and billing activities; or
- (d) Time the individual spends in segregated facility-based settings activities.

- A description of what occurred during the encounter or service interval to justify billing.

March 2010

- The Agency billed 112 units of Community Access from 3/1/2010 through 3/15/2010. Documentation provided accounted for 44 units in March per time in/time out. Documentation did not contain the following:
 - A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes (2 service intervals on documented on 1 page with 1 staff signature).
 - A description of what occurred during the encounter or service interval to justify billing.

Individual #13
January 2010

- The Agency billed 18 units of Community Access from 1/16/2010 through 1/31/2010. No documentation was provided to justify billing.

March 2010

- The Agency billed 46 units of Community Access from 3/1/2010 through 3/15/2010. Documentation did not contain the following:
 - A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes (2 service intervals on documented on 1 page with 1 staff signature).
 - A description of what occurred during the encounter or service interval to justify

	<p>billing.</p> <p>Individual #17 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 80 units of Community Access from 1/1/2010 through 1/15/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes (2 service intervals on documented on 1 page with 1 staff signature). ◦ A description of what occurred during the encounter or service interval to justify billing. • The Agency billed 132 units of Community Access from 1/16/2010 through 1/31/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes (2 service intervals on documented on 1 page with 1 staff signature). ◦ A description of what occurred during the encounter or service interval to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 66 units of Community Access from 2/1/2010 through 2/15/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes (2 service intervals on documented 		
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	<p>on 1 page with 1 staff signature).</p> <ul style="list-style-type: none">◦ A description of what occurred during the encounter or service interval to justify billing.		
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Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES</p> <p>A. Support to Individuals in Family Living: The Family Living Services Provider Agency shall provide and document:</p> <p>(5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include:</p> <p>(a) Review, advise, and prompt the implementation of the individual's ISP Action Plans, schedule of activities and appointments; and</p> <p>(b) Assist with service or support issues raised by the direct support provider or observed by supervisor, service coordinator or other IDT members.</p> <p>B. Home Studies. The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS</p>	<p>Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 2 of 19 individuals.</p> <p>The following was not found, not current and/or incomplete:</p> <ul style="list-style-type: none"> • Monthly Consultation with the Direct Support Provider <ul style="list-style-type: none"> ◦ Individual #8 - None found for 4/2010. • Family Living (Initial) Home Study <ul style="list-style-type: none"> ◦ Individual #13 - Not Found. 		

D. Scope of DDSD Agreement

- (4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite;

NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER

ELIGIBLE PROVIDERS:

I. Qualifications for community living service providers: There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards.

(1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.

Tag # 6L14 Residential Case File	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>A. Residence Case File: For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:</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 11 of 19 Individuals receiving Family Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ Health Plan/Insurance Information (#10) • Positive Behavioral Plan (#4, 9 & 16) • Positive Behavioral Crisis Plan (#9) • Speech Therapy Plan (#19) • Occupational Therapy Plan (#13) • Physical Therapy Plan (#15) • Health Care Plans <ul style="list-style-type: none"> ◦ Seizures (#2) ◦ Asthma (#2) • Crisis Plan <ul style="list-style-type: none"> ◦ Allergies (#4) ◦ Diabetes (#4 & 5) ◦ Asthma (#13) ◦ Seizures (15) • Progress Notes/Daily Contacts Logs: <ul style="list-style-type: none"> ◦ Individual #7 - None found for 5/1 – 26/2010 • Data Collection/Data Tracking: <ul style="list-style-type: none"> ◦ Individual #19 - None found for 5/1 – 25/2010 • Health Care Providers Written Orders (#7) 	

<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"> (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: <ul style="list-style-type: none"> (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. <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,</p>	<ul style="list-style-type: none"> • Record of visits of healthcare practitioners (#19) 		
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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 # 6L17 Reporting Requirements (Community Living Quarterly Reports)	Scope and Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>D. Community Living Service Provider Agency Reporting Requirements: All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation:</p> <ol style="list-style-type: none"> (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members. 	<p>Based on record review, the Agency failed to complete written quarterly status reports for 2 of 20 individuals receiving Community Living Services.</p> <p>Family Living Quarterly Reports:</p> <ul style="list-style-type: none"> • Individual #3 - None found for 8/2009 - 4/2010 • Individual #6 - None found for 1/2010 <p>Note: Agency completes monthly reports.</p>		

Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: F		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>L. Residence Requirements for Family Living Services and Supported Living Services</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"> (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence; (b) General-purpose first aid kit; (c) When applicable due to an individual's health status, a blood borne pathogens kit; (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats; (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone; (f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift; (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. 	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 15 of 15 Family Living residences.</p> <p>Individuals #12 & 15 live in the same residence.</p> <p>The following items were not found, not functioning or incomplete:</p> <p>Family Living Requirements:</p> <ul style="list-style-type: none"> • General-purpose first aid kit (#12 & 15) • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#2, 4, 6, 9, 14 & 16) • Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#2 & 19) • 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 (#2, 4, 6, 8, 9, 12, 14, 15, 16 & 17) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 15, 16, 17 & 19) 		

Tag # 6L27 FL Reimbursement	Scope and Severity Rating: C	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</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>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. IX. REIMBURSEMENT FOR</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 19 of 19 individuals.</p> <p>Individual #1 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 1/8/2010 through 2/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 2/8/2010 through 3/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #2 February 2010</p>	

COMMUNITY LIVING SERVICES

B. Reimbursement for Family Living Services

(1) Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year.

(2) Billable Activities shall include:

- (a) Direct support provided to an individual in the residence any portion of the day;
- (b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and
- (c) Any other activities provided in accordance with the Scope of Services.

(3) Non-Billable Activities shall include:

- (a) The Family Living Services Provider Agency may not bill the for room and board;
- (b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and
- (c) Family Living services may not be billed for the same time period as Respite.
- (d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one midnight to the following midnight.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **Chapter 6 -**

COMMUNITY LIVING SERVICES

III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES

C. Service Limitations. Family Living Services cannot be provided in conjunction with any other Community Living Service, Personal Support Service, Private Duty Nursing, or Nutritional

- The Agency billed 5 units of Family Living from 2/8/2010 through 2/12/2010. Documentation did not contain the following:

- A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes.
- A start and end time to justify billing.
- A description of what occurred during the encounter or service interval to justify billing.

- The Agency billed 14 units of Family Living from 2/14/2010 through 3/7/2010. Documentation did not contain the following:

- A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes.
- A start and end time to justify billing.
- A description of what occurred during the encounter or service interval to justify billing.

Individual #3
January 2010

- The Agency billed 31 units of Family Living from 1/8/2010 through 2/7/2010. Documentation did not contain the following:

- A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes.

Counseling. In addition, Family Living may not be delivered during the same time as respite; therefore, a specified deduction to the daily rate for Family Living shall be made for each unit of respite received.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **DEFINITIONS**
SUBSTITUTE CARE means the provision of family living services by an agency staff or subcontractor during a planned/scheduled or emergency absence of the direct service provider.

RESPITE means a support service to allow the primary caregiver to take a break from care giving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.

- A start and end time to justify billing.
- A description of what occurred during the encounter or service interval to justify billing.

February 2010

- The Agency billed 28 units of Family Living from 2/8/2010 through 3/7/2010. Documentation did not contain the following:
 - A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes.
 - A start and end time to justify billing.
 - A description of what occurred during the encounter or service interval to justify billing.

Individual #4

January 2010

- The Agency billed 22 units of Family Living from 1/8/2010 through 1/29/2010. Documentation did not contain the following:
 - A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes.
 - A start and end time to justify billing.
 - A description of what occurred during the encounter or service interval to justify billing.

February 2010

- The Agency billed 4 units of Family Living from

	<p>2/4/2010 through 2/7/2010. Documentation did not contain the following:</p> <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 2/8 through 3/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #5 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 1/8/2010 through 2/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. 		
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	<ul style="list-style-type: none"> ◦ A description of what occurred during the encounter or service interval to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 2/8/2010 through 3/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #6 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 1/8/2010 through 2/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 27 units of Family Living from 2/8/2010 through 3/6/2010. Documentation did 		
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	<p>not contain the following:</p> <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #7 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 3 units of Family Living from 1/5/2010 through 1/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. • The Agency billed 4 units of Family Living from 1/12/2010 through 1/15/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. 		
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	<ul style="list-style-type: none"> ◦ A description of what occurred during the encounter or service interval to justify billing. • The Agency billed 4 units of Family Living from 1/19/2010 through 1/22/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. • The Agency billed 5 units of Family Living from 1/25/2010 through 1/27/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 7 units of Family Living from 2/1/2010 through 2/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained 		
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	<p>only one signature for each set of progress notes.</p> <ul style="list-style-type: none"> ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 2/8/2010 through 3/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #8 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 1/8/2010 through 2/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. 		
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	<p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 2/8/2010 through 3/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #9 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 1/8/2010 through 2/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 2/8/2010 through 3/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress 		
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	<p>notes.</p> <ul style="list-style-type: none"> ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #10 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 5 units of Family Living from 1/3/2010 through 1/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. • The Agency billed 4 units of Family Living from 1/10 through 1/13/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. • The Agency billed 23 units of Family Living from 		
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	<p>1/16/2010 through 2/7/2010. Documentation did not contain the following:</p> <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 26 units of Family Living from 2/8/2010 through 3/5/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #11 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 1/8/2010 through 2/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. 		
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	<ul style="list-style-type: none"> ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 2/8/2010 through 3/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #12 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 1/8/2010 through 2/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 		
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	<p>2/8/2010 through 3/7/2010. Documentation did not contain the following:</p> <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #13 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 15 units of Family Living from 1/8/2010 through 1/22/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. • The Agency billed 6 units of Family Living 1/24/2010 through 1/29/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. 		
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	<ul style="list-style-type: none"> ◦ A description of what occurred during the encounter or service interval to justify billing. • The Agency billed 1 unit of Family Living on 1/31/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 6 units of Family Living from 2/2/2010 through 2/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. • The Agency billed 18 units of Family Living from 2/9/2010 through 2/26/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for 		
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	<p>each unit billed. Documentation contained only one signature for each set of progress notes.</p> <ul style="list-style-type: none"> ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>March 2010</p> <ul style="list-style-type: none"> • The Agency billed 5 units of Family Living from 3/1/2010 through 3/5/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #14 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 1/8/2010 through 2/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify 		
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	<p>billing.</p> <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 2/8/2010 through 3/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #15</p> <p>January 2010</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 1/8/2010 through 2/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 2/8/2010 through 3/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for 		
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	<p>each unit billed. Documentation contained only one signature for each set of progress notes.</p> <ul style="list-style-type: none"> ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #16 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 1/8/2010 through 2/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 2/8/2010 through 3/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify 		
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	<p>billing.</p> <p>Individual #17 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 1/8/2010 through 2/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 2/8/2010 through 3/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #18 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living from 1/8/2010 through 2/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff 		
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	<p>providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes.</p> <ul style="list-style-type: none"> ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 2/8/2010 through 3/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>Individual #19 February 2010</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 2/8/2010 through 3/7/2010. Documentation did not contain the following: <ul style="list-style-type: none"> ◦ A signature/authenticated name of the staff providing the service to justify billing for each unit billed. Documentation contained only one signature for each set of progress notes. ◦ A start and end time to justify billing. ◦ A description of what occurred during the 		
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	encounter or service interval to justify billing.		
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