



Alfredo Vigil, MD
Secretary

DEPARTMENT OF

Building a Healthy New Mexico!

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Deputy Secretary

Duffy Rodriguez
Deputy Secretary

Jessica Sutin
Deputy Secretary

Karen Armitage, MD
Chief Medical Officer

Date: January 19, 2010

To: Anita Westbrook, Executive Director of the Office of Facilities Management
Provider: Los Lunas Community Program/NMDOH
Address: 445 Camino Del Ray SW, Suite A
State/Zip: Los Lunas, New Mexico, 87031

CC: Katrina Hotrum, Deputy Secretary, Department of Health (Board Chair)

Region: Metro

Original Survey Date: February 23 - 27, 2009

Verification Survey Date: November 2 - 4, 2009

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation, Supported Employment & Community Access)

Survey Type: Verification Survey

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

Team Members: Cyndi Nielsen, MSN, RN, ONC, CCM, Clinical Liaison, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Valerie V. Valdez, MS, Health Program Manager, Division of Health Improvement/Quality Management Bureau; Barbara Czinger, MSW, LISW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Florie Alire, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Stephanie Martinez de Berenger, MPA, GCDF, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; & Judy Parks, MSE, Deputy Director, Division of Health Improvement.

Ms. Westbrook,

The Division of Health Improvement Quality Management Bureau has completed a Plan of Correction Follow-up survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI/DDSD regarding the routine survey on **February 23 - 27, 2009**.

These findings will be reviewed by the DOH – Internal Review Committee during an upcoming review meeting. The findings are attached.

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:

“Assuring safety and quality of care in New Mexico’s health facilities and community-based programs.”

David Rodriguez, Division Director • Division of Health Improvement

Division of Health Improvement • Quality Management Bureau • 5301 Central Ave NE • Suite 400 • Albuquerque, New Mexico 87108
(505) 222-8633 • FAX: (505) 222-8661

DHI Quality Review Survey Report – Los Lunas Community Program - Metro Region - November 2 - 4, 2009

Survey Report #: Q10.02.D1977.METRO.001.VS.01

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

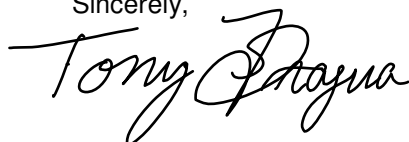
A request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 working days. Providers may not appeal the nature or interpretation of the standard or regulation, the team composition, sampling methodology or the Scope and Severity of the finding.

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

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

Please call the Team Leader at 505-231-7436, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

A handwritten signature in black ink that reads "Tony Fragua". The signature is written in a cursive style with a large, stylized initial "T".

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

Survey Process Employed:

Entrance Conference Date: November 2, 2009

Present:

Los Lunas Community Program

Anita Westbrook, Executive Director
Andrew Smith, Residential Coordinator
Dorothy Maya, Residential Coordinator
Ruth Castillo, Residential Coordinator
Annette Baca, Residential Coordinator
Reginald Allen, Deputy Executive Manager
Angie Brooks, Acting Program Manager
Vicky Baker, Service Coordinator
Raul Montano, Service Coordinator
David Aragon, Director of Service Coordinators
Debbie Duffee, RN
Rosalie Leyba, Service Coordinator
Virginia Aragon, Service Coordinator
Paula Jean Walker, Service Coordinator/Secretary

DOH/DHI/QMB

Tony Fragua, BFA, Team Lead/Healthcare Surveyor
Cyndi Nielsen, MSN, RN, ONC, CCM, Clinical Liaison/Healthcare Surveyor
Florie Alire, RN, Healthcare Surveyor
Barbara Czinger, MSW, LISW, Healthcare Surveyor
Stephanie Martinez de Berenger, MPA, Healthcare Surveyor
Judy Parks, MSE, Deputy Director

Exit Conference Date: November 4, 2009

Present:

Los Lunas Community Program

Anita Westbrook, Executive Director
Angie Brooks, Acting Program Manager
Raul Montano, Service Coordinator
Virginia Chavira, Day Habilitation Manager
Amanda Aragon, Day Habilitation Service Coordinator
Virginia Aragon, Day Habilitation Service Coordinator
Kelly Ann Scalf, Employment Supervisor
Debra Humiston, RN
David Aragon, Director of Service Coordinators
Andrew Smith, Residential Coordinator
Dorothy Maya, Residential Coordinator
Ruth Castillo, Residential Coordinator
Annette Baca, Residential Coordinator
Colleen Montoya, Records Manager
Paula Jean Walker, Service Coordinator/Secretary

DOH/DHI/QMB

Tony Fragua, BFA, Team Lead/Healthcare Surveyor
Valerie V. Valdez, MS, Healthcare Program Manager/Healthcare Surveyor
Cyndi Nielsen, MSN, RN, ONC, CCM, Clinical Liaison/Healthcare Surveyor
Florie Alire, RN, Healthcare Surveyor
Barbara Czinger, MSW, LISW, Healthcare Surveyor
Stephanie Martinez de Berenger, MPA, Healthcare Surveyor
Judy Parks, MSE, Deputy Director

Homes Visited	Number:	15
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	22 11 - Jackson Class Members 11 - Non-Jackson Class Members 15 - Supported Living 7 - Family Living 18 - Adult Habilitation 3 - Community Access 4 - Supported Employment
Persons Served Observed	Number:	19 (19 individuals at the homes during on-site visit no interviews were conducted)
Records Reviewed (Persons Served)	Number:	22
Administrative Files Reviewed		<ul style="list-style-type: none"> • 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 • Quality Improvement/Quality Assurance Plan • Medical Protocol for individuals and staff who administer medication involving Metamucil

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

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

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

Attachment B

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

Key to Scope scale:

Isolated:

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

Pattern:

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

Widespread:

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

Key to Severity scale:

Low Impact Severity: (Blue)

Low level findings have no or minimal potential for harm to an individual. Providers that have no findings above a "C" level may receive a "Quality" Certification approval rating from QMB.

Medium Impact Severity: (Tan)

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

High Impact Severity: (Green or Yellow)

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

High Impact Severity: (Yellow)

"J, K, and L" Level findings:

This is a finding of Immediate Jeopardy. If a provider is found to have "I" level findings or higher, with an outcome of Immediate Jeopardy, including repeat findings or Conditions of Participation they will be referred to the Internal Review Committee.

The QMB Approval Rating

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

"Quality" Approval Rating:

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

"Merit" Approval Rating:

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

"Standard" Approval Rating:

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

"Sub-Standard" Approval Rating:

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

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

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

"Provisional" Approval Rating:

New DD service providers may qualify for a QMB "Provisional" Approval Rating upon successfully completing their initial QMB Quality Survey.

The QMB DD Manager will review the Report of Findings and determine if the provider has achieved at least a standard rating of approval. If successful, the provider may receive a one (1) year contract extension. QMB will notify the DDS Contract unit of the "Provisional" approval rating.

Attachment C

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

Introduction:

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

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

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

The following limitations apply to the IRF process:

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

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

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

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

Administrative Review Process:

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

Regarding IRC Sanctions:

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

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

Agency: Los Lunas Community Program - Metro Region
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Routine
Date of Original Survey: February 23 - 27, 2009
Date of Verification Survey: November 2 - 4, 2009

Statute	February 23 - 27, 2009 Deficiencies	November 2 - 4, 2009 Verification Survey - New and Repeat Deficiencies
Tag # 1A08 Agency Case File	Scope and Severity Rating: B	Scope and Severity Rating: NA
<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>(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</p>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 10 of 26 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"> • Annual ISP (#14 & 19) • ISP Signature Page (#1, 3, 10, 13, 19, 21 & 24) • Addendum A (#1, 3, 5, 9, 10, 12, 19, 23 & 24) • Individual Specific Training (Addendum B) (#10 & 19) • Occupational Therapy Plan (#3 & 6) • Physical Therapy Plan (#8) 	<p>Complete</p>

<p>and telephone number, and health plan if appropriate;</p> <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> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p>		
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Tag # 1A09 Medication Delivery (MAR)	Scope and Severity Rating: E	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> <ol style="list-style-type: none"> 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; Prescribed dosage, frequency and method/route of administration, times and dates of administration; Initials of the individual administering or assisting with the medication; Explanation of any medication irregularity; Documentation of any allergic reaction or adverse medication effect; and For PRN medication, an explanation for the 	<p>Medication Administration Records (MAR) were reviewed for the months of October, November, December 2008, and February 2009.</p> <p>Based on record review, 12 of 24 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #1 November 2008 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> Depakote 250mg (2 times daily) Blank - 11/30 (9PM). <p>Individual #2 October 2008 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> Tegretol 200mg (3 times daily) - Blank - 10/31 (12PM) <p>Individual #3 December 2008 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> Namenda 5mg (1 time daily) - Blank - 12/30 (8AM) <p>Individual #4 October 2008 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> Topamax 100mg (2 times daily) - Blank - 10/30 (7:30AM) 	<p>New and Repeat Findings</p> <p>Medication Administration Records (MAR) were reviewed for the months of August, September, 2009, and November 2009.</p> <p>Based on record review, 14 of 21 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #1 During on-site survey (November 2 - 4, 2009) Physician Orders were requested. As of 11/4/2009, Physician Orders had not been provided.</p> <p>Individual #3 During on-site survey (November 2 - 4, 2009) Physician Orders were requested. As of 11/4/2009, Physician Orders had not been provided.</p> <p>Individual #7 August 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> Simethicone 120mg (4 times daily) – Blank 8/31 (7PM) <p>Individual #8 During on-site survey (November 2 - 4, 2009) Physician Orders were requested. As of 11/4/2009, Physician Orders had not been provided.</p> <p>Individual #9 During on-site survey (November 2 - 4, 2009) Physician Orders were requested. As of 11/4/2009, Physician Orders had not been provided.</p> <p>Individual #11 During on-site survey (November 2 - 4, 2009)</p>

<p>use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>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 or changed; 	<ul style="list-style-type: none"> • Tegretol 200mg (2 times daily) - Blank - 10/30 (7:30AM & 2PM) • Baclofen 10mg tab (2 times daily) - Blank - 10/30 (7AM & 2:30PM) • Ferrous Sulfate 200mg/5ml (3 times daily) - Blank - 10/30 (7:30AM & 5PM) • Prilosec 20mg (2 times daily) - Blank - 10/30 (7AM & 5PM) • Reglan 10mg (3 times daily) - Blank - 10/30 (7:00AM, 11AM & 5PM) • Oyster Calcium 1500mg (2 times daily) - Blank - 10/30 (7:30AM & 5:30PM) • Vitamin D 1000 IU (2 times daily) - Blank - 10/30 (7:30AM & 5:30PM) <p>Medication Administration Records did not contain diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Seasonelle (Daily) • Alendronate Sodium 70mg (1 time weekly) <p>November 2008 Medication Administration Records did not contain diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Seasonelle (Daily) • Alendronate Sodium 70mg (1 time weekly) <p>Individual #8 October 2008 During on-site survey Medication Administration Records were requested for months of October, November, and December 2008. As of February 27, 2009, October 2008 Medication Administration Records had not been provided.</p>	<p>Physician Orders were requested. As of 11/4/2009, Physician Orders had not been provided.</p> <p>Individual #14 September 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Levothroid 75mcg (1 time daily) – Blank 9/11 (8 AM) <p>Individual #15 August 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Calcium 600mg+Vit D (2 times daily) – Blank 8/31 (7AM) • Multivitamin (1 time daily) – Blank 8/31 (7AM) • Docusate Sodium 100mg (1 time daily) – Blank 8/31 (7AM) • Oxybutynin 5mg (2 times daily) – Blank 8/31 (7AM) • Metamucil Powder (1 time daily) – Blank 8/31 (7AM) <p>Individual #16 August 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Forteo INJ 750mcg/3ml (1 time daily) – Blank 8/27 & 28 (4PM) <p>Individual #17 August 2009 Medication Administration Records contained</p>
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<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>November 2008</p> <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"> • Tretinoin 0.25% cream 45gm • Ibuprofen 600mg (2 times daily) • Ibuprofen 400mg (2 times daily) • Loratadine 10mg <p>Medication Administration Records contained missing entries. MAR noted specific time frames for medications to be given. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Ibuprofen 600mg (2 times daily) - MAR indicates to be given at 9AM, 12PM & 3PM - Blank - November 1, 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (9AM); November 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (12PM); & November 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (3PM). • Ibuprofen 400mg - MAR indicates to be given at 9AM - Blank - November 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (9AM). • Loratadine 10mg - MAR indicates to be given at 8AM - Blank - November 14, 15, 16 & 18 (8AM). <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Tretinoin 0.25% cream 45gm <p>Medication Administration Records did not contain the frequency the medication is to be given:</p>	<p>missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Beneprotein Powder (3 times daily) – Blank 8/30 (8:30PM & 11:30PM) & 8/31(4AM) • Pulmicort Respules (2 times daily) – Blank 8/30 (9PM) <p>Individual #21 August 2009 Medication Administration Record did not contain the form (i.e. liquid, Crushed tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Synthroid 50mcg (1 times daily) <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Lisinopril 10mg (1 time daily) – Blank 8/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 & 13 (7:30AM) Blank 8/17, 18 & 20 (7:30AM) <p>Medication Administration Records do not indicate whether the following sliding scale used for Insulin contain the specific time(s) the medication should be given, no time was given for the following medications:</p> <ul style="list-style-type: none"> • Novolog Insulin SS- Regular 0 units • CBG 151 – 200 give 1 unit • CBG 201 – 250 give 2 units • CBG 251 – 300 give 3 units • CBG 301 – 350 give 4 units • CBG 351 – 400 give 10 units <p>September 2009 Medication Administration Records do not indicate</p>
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	<ul style="list-style-type: none"> • Loratadine 10mg • Tretinoin 0.25% cream 45gm <p>Per Medication Administration Records the individual is to take Ibuprofen 400mg 2 times daily. MAR indicates medication is to be given at 9AM. Per Physician's Orders Ibuprofen 400mg is to be taken 2 times daily as needed Medication Administration Record & Physician's Orders do not match.</p> <p>Per Medication Administration Records the individual is to take Ibuprofen 600mg 2 times daily. MAR indicates medication is to be given at 9AM, 12PM, & 3PM. Per Physician's Orders individual is to take Ibuprofen 400mg 2 times daily as needed. Medication Administration Record & Physician's Orders do not match.</p> <p>Review of Medication Administration Record found November 2008 MAR had 31 days of medication documented for Vitamin B-50 & Calcium 500mg, as being given. The month of November only contains 30 days.</p> <p>December 2008 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"> • Tretinoin 0.25% cream 45gm Ibuprofen 600mg (2 times daily) • Ibuprofen 200mg • Loratadine 10mg • Loperanide Hydrochloride Oral Solution • Pepto Bismol <p>Medication Administration Records did not contain the frequency the medication is to be given:</p> <ul style="list-style-type: none"> • Tretinoin 0.25% cream 45gm • Loperanide Hydrochloride Oral Solution 	<p>whether the following sliding scale used for Insulin contain the specific time(s) the medication should be given, no time was given for the following medications:</p> <ul style="list-style-type: none"> • Novolog Insulin SS- Regular 0 units – 9/5, 6, 13, 14, 17, 20 & 21 (given 1 time); 9/7 & 19 (given 2 times) & 9/28 (given 3 times) • CBG 151 – 200 give 1 unit – 9/1, 6, 7, 11, 20, 21, 27 & 28 (given 1 time); 9/3, 9/4 & 9/5 (given 2 times); 9/8, 9, 12, 15 & 25 (given 2 times) & 9/14, 16 & 17 (given 3 times) • CBG 201 – 250 give 2 units – 9/5, 7, 9, 15, 16, 19, 20, 21, 22, 23 & 28 (given 1 time); 9/6, 12 & 25 (given 2 times); 9/1, 2, 3, 11, 18, 24, 26, 27 & 30 (given 3 times) & 9/10 & 29 (given 4 times). • CBG 251 – 300 give 3 units – 9/2, 8, 15, 20, 21, 24 & 25 (given 1 time); 9/4, 13 & 23 (given 2 times) & 9/22 (given 3 times) • CBG 301 – 350 give 4 units – 9/23 & 9/30 (given 1 time) • CBG 351 – 400 give 10 units <p>Individual # 22 August, 2009 Medication Administration Record did not contain the form (i.e. liquid, Crushed, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Mylicon 80mg (1 time daily) • Phenobarbital 32.4 mg (1 time daily) • Multivitamin (1 time daily) • Fiber Tabs (1 time daily) • Colace 100mg (2 times daily)
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	<ul style="list-style-type: none"> • Pepto Bismol <p>Per Medication Administration Records the individual is to take Ibuprofen 600mg 1 time daily. MAR indicates medication is to be given at 1PM & 6PM. Per Physician's Orders individual is to take Ibuprofen 400mg 2 times daily as needed. Medication Administration Record & Physician's Orders do not match.</p> <p>Per Medication Administration Records the individual is to take Ibuprofen 200mg. MAR indicates medication is to be given at 9AM. Per Physician's Orders individual is to take Ibuprofen 400mg 2 times daily as needed. Medication Administration Record & Physician's Orders do not match.</p> <p>Medication Administration Records contain the following medications, yet no Physician's Orders were found:</p> <ul style="list-style-type: none"> • Loperanide Hydrochloride Oral Solution • Pepto Bismol <p>Medication Administration Records contained missing entries. MAR noted specific time frames for medications to be given. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Calcium 500mg MAR indicates to be given at 6PM - Blank - 12/18 (6PM) • Tretinoin 0.25% cream 45gm - MAR has no indication of when medication is to be given - Blank 12/1, 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. • Ibuprofen 600mg (1 time daily) - MAR indicates to be given at 1PM & 6PM - Blank - 12/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 19, 	<ul style="list-style-type: none"> • Reglan 5mg (1 time daily) • Lactulose 30cc (1 time daily) • Prilosec 20mg (2 times daily) • Ambien 10mg (1 time daily) <p>Individual #24 August 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Trazadone 100mg (1 time daily) – Blank 8/24 (8PM) <p>Individual #25 During on-site survey (November 2 - 4, 2009) Physician Orders were requested. As of 11/4/2009, Physician Orders had not been provided.</p>
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20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (1PM) & 12/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31(6PM).

- Loratadine 10mg - MAR indicates to be given at 8AM - Blank -12/9, 14, 16, 18 & 27 (8AM)
- Ibuprofen 200mg - MAR indicates to be given at 9AM - Blank - 12/1, 3, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (9AM).
- Loperanide Hydrochloride Oral Solution - MAR indicates to be given at 9AM & 10 PM - Blank - 12/1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (9AM) & 12/1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (10PM)
- Pepto Bismol MAR indicates to be given at 6PM & 10 PM - Blank - 12/1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (6PM) & 12/1, 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 (10PM)

Individual #9
October 2008

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Buspar 10 mg (1 time daily)

November 2008

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Buspar 10 mg (1 time daily)

	<p>December 2008 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Buspar 10 mg (1 time daily) <p>Individual #13 October 2008 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Colace 100mg (2 times daily) Blank - 10/23 (8PM) <p>February 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Amaryl (Glimepiride) 2mg (1 time daily) Clonidine 0.2mg (2 times daily) <p>Individual #14 February 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Levothyroxine 0.50mg (1 time daily) Docusate Sodium 100mg (2 times daily) • Prilosec 20mg 2 tabs (1 time daily) • Celebrex 200mg (1 time daily) <p>Individual #16 October 2008 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Loratadine 10mg (1 time daily) • Famotidine 20mg (1 time daily) • Forteo 750mcg/3ml inject 20mcg subcutaneously (1 time daily) 	
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Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

- Calci Chew tab (2 times daily) - Blank - 10/16, 17 & 20 (7PM)
- Cipro Otic (4 times daily for 30 days) - Blank - 10/13 (7PM), 10/17 (7PM); 10/19 (7AM,11AM & 3PM); 10/20 (7AM, 11AM & 3PM); 10/21 (7AM, 11AM & 3PM); 10/24 (7PM); 10/27 (7AM & 11AM); 10/28 (3:PM & 7PM); 10/29 (3PM & 7PM) & 10/31 (3PM).

November 2008

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Loratadine 10mg (1 time daily)
- Famotidine 20mg (1 time daily)
- Forteo 750mcg/3ml inject 20mcg subcutaneously (1 time daily)

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

- Forteo 750mcg/3ml inject 20mcg subcutaneously (1 time daily) - Blank - 11/14 & 30 (4PM)
- Cipro Otic (4 times daily for 30 days) - - Blank- 11/30 (3PM & 7PM)

December 2008

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

- Cipro Otic (4 times daily for 30 days) - Blank- 12/18 (7AM & 11AM), 12/20 (7AM & 11AM) & 12/21 (7AM & 11AM)

February 2009

Medication Administration Records did not contain the diagnosis for which the medication is

prescribed:
• Acidophilus 2 tabs (1 time daily)
• Gentamycin Otic drops 4 drops (4 times daily)

Individual #24
February 2009

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Clonazepam 2mg (3 times daily)
- Neurontin 400mg (3 times daily)
- Buspar 20mg (3 times daily)
- Melatonin 3mg (1 time daily)
- Roloids 1 tab (3 times daily)
- Benzaclin Gel (2times daily)

Individual #25
October 2008

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Namenda 5mg (1 time daily)

Individual #26
October 2008

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Prenatal Vitamin (1 times daily)
- Evista 60mg (1 time daily)
- Lisinopril 20mg (1 time daily)

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

- Lisinopril 20mg (1 time daily) Blank - 10/31 (4PM)

November 2008

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Prenatal Vitamin (1 time daily)
 - Evista 60mg (1 time daily)
 - Lisinopril 20mg (1 time daily)
- Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Cephalexin 500mg (3 times daily) Blank - 11/28 (8PM)
- December 2008
- Medication Administration Records did not contain the diagnosis for which the medication is prescribed:
- Prenatal Vitamin (1 time daily)
 - Evista 60mg (1 time daily)
 - Lisinopril 20mg (1 time daily)

Tag # 1A09 Medication Delivery - PRN	Scope and Severity Rating: D	Scope and Severity Rating: D
<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> <ol style="list-style-type: none"> 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; Prescribed dosage, frequency and method/route of administration, times and dates of administration; Initials of the individual administering or assisting with the medication; Explanation of any medication irregularity; Documentation of any allergic reaction or adverse medication effect; and For PRN medication, an explanation for the 	<p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 2 of 24 Individuals.</p> <p>Individual #8 October 2008 During on-site survey Medication Administration Records were requested for months of October, November, and December 2008. As of February 27, 2009, October 2008 Medication Administration Records had not been provided.</p> <p>November 2008 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"> Tretinoin 0.25% cream 45gm Ibuprofen 600mg (2 times daily) Ibuprofen 400mg (2 times daily) Loratadine 10mg <p>Medication Administration Records do not indicate if medications are Routine or PRN. Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> Tretinoin 0.25% cream 45gm <p>Medication Administration Records do not indicate if medications are Routine or PRN. Medication Administration Records did not contain the frequency the medication is to be given and/or the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> Loratadine 10mg Tretinoin 0.25% cream 45gm Ibuprofen 200mg <p>Per Medication Administration Records the individual is to take Ibuprofen 400mg 2 times daily.</p>	<p>New and Repeat Findings</p> <p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 3 of 21 Individuals.</p> <p>Individual #4 August 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> Claritin 10mg (PRN) <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> Albuterol (PRN) <p>September 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> Claritin 10mg (PRN) <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> Albuterol (PRN) <p>Individual #5 August 2009 No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> Ibuprofen 600mg – PRN – 8/20 & 25 (given 1 time) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> Ibuprofen 600mg – PRN – 8/28 (given 2 times) <p>No Effectiveness was noted on the Medication</p>

<p>use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>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 or changed; (x) The name and initials of all staff 	<p>MAR indicates medication is to be given at 9AM. Per Physician's Orders Ibuprofen 400mg is to be taken 2 times daily as needed Medication Administration Record & Physician's Orders do not match.</p> <p>Per Medication Administration Records the individual is to take Ibuprofen 600mg 2 times daily. MAR indicates medication is to be given at 9AM, 12PM, & 3PM. Per Physician's Orders individual is to take Ibuprofen 400mg 2 times daily as needed. Medication Administration Record & Physician's Orders do not match.</p> <p>Medication Administration Record does not indicate if medications are Routine or PRN. No effectiveness noted for PRN medication:</p> <ul style="list-style-type: none"> • Ibuprofen 600mg (2 times daily) - 11/9 (12PM); 11/10 (9AM & 3PM) & 11/11 (9AM). <p>December 2008 Medication Administration Records do not indicate whether the following medications are Routine or PRN for medications and do not include required information as per standard:</p> <ul style="list-style-type: none"> • Tretinoin 0.25% cream 45gm • Ibuprofen 600mg (2 times daily) • Ibuprofen 200mg • Loratadine 10mg • Loperanide Hydrochloride Oral Solution • Pepto Bismol <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Tretinoin 0.25% cream 45gm <p>Medication Administration Records did not indicate if medications are Routine or PRN. Medication Administration Records did not contain the frequency the medication is to be given and/or the</p>	<p>Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Ibuprofen 600mg – PRN – 8/28 (given 2 times) <p>Individual #20 August 2009 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Albuterol Neb Soln 0.083% – PRN – 8/1, 3 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 23, 27 & 30 (given 1 time daily) • Benadryl 25mg– PRN – 8/10, 11, 12, 13, 15, 16, 17, 18, 19, 20, 21, 23, 24, 25, 27, 30 and 31 (given 1 time daily) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Albuterol Neb Soln 0.083% – PRN – 8/1, 3, 4, 5, 6, 7, 8, 11 12, 13, 14, 15, 17, 18, 19, 20, 21, 23, 27 & 30 (given 1 time daily) • Benadryl 25mg – PRN – 8/10 11, 12, 13, 15, 16, 17, 18, 19, 20, 21, 23, 24, 25, 27, 30, 31 (given 1 time daily) <p>September 2009 No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Albuterol Neb Soln 0.083% – PRN – 9/3 (given 1 time daily) • Benadryl 25mg– PRN – 9/1 (given 1 time daily) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Albuterol Neb Soln 0.083% – PRN – 9/3 (given 1
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<p>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>exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Tretinoin 0.25% cream 45gm • Loperanide Hydrochloride Oral Solution • Pepto Bismol <p>Medication Administration Records did not indicate if medications are routine or PRN. No effectiveness noted for PRN medication:</p> <ul style="list-style-type: none"> • Ibuprofen 600mg (2 times daily) - 12/16 (6PM) & 12/18 (1PM) • Loperanide Hydrochloride Oral Solution -12/9 (10PM) & 12/10 (9AM) • Pepto Bismol - 12/10 (10 PM & 6PM) & 12/11 (10PM) <p>Per Medication Administration Records the individual is to take Ibuprofen 600mg 1 time daily. MAR indicates medication is to be given at 1PM & 6PM. Per Physician's Orders individual is to take Ibuprofen 400mg 2 times daily as needed. Medication Administration Record & Physician's Orders do not match.</p> <p>Per Medication Administration Records the individual is to take Ibuprofen 200mg. MAR indicates medication is to be given at 9AM. Per Physician's Orders individual is to take Ibuprofen 400mg 2 times daily as needed. Medication Administration Record & Physician's Orders do not match.</p> <p>Individual #9 October 2008 Medication Administration Records did not contain the circumstance in which the medication is to be given:</p> <ul style="list-style-type: none"> • Mucinex 600mg (2 times daily) <p>November 2008</p>	<p>time daily)</p> <ul style="list-style-type: none"> • Benadryl 25mg– PRN – 9/1 (given 1 time daily) • Tylenol 10mg – PRN – 9/11 (given 1 time daily) <p>Individual #24 August 2009 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 200mg (PRN) <p>September 2009 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 200mg (PRN)
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	<p>Medication Administration Records did not contain the circumstance in which the medication is to be given:</p> <ul style="list-style-type: none">• Mucinex 600mg (2 times daily) <p>December 2008</p> <p>Medication Administration Records did not contain the circumstance in which the medication is to be given:</p> <ul style="list-style-type: none">• Mucinex 600mg (2 times daily)	
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Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: D	Scope and Severity Rating: D
<p>Developmental Disabilities (DD) Waiver Service Standards 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>(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.</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 3 of 26 individuals.</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Quarterly Nursing Review if HCP/Crisis Plans <ul style="list-style-type: none"> ◦ 1/2008 - 6/2008 (#3) • Special Health Care Needs: <ul style="list-style-type: none"> ◦ Meal Time Plan (#11) (Is required per Individual's ISP Individual Specific Training Section) ◦ Nutritional Evaluation (#26) (Per individual's ISP the individual is required to have one completed annually). No evidence found of evaluation being completed. 	<p>New Findings</p> <p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 1 of 22 individuals.</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Health Care Plans <ul style="list-style-type: none"> ◦ Individual #15 - As indicated by the IST section of ISP the individual is required to have a plan.

However, the agency nurse must be available to assist the caregiver upon request.

(c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first.

(d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy).

(e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as *subjective* information including the individual complaints, signs and symptoms noted by staff, family members or other team members; *objective* information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.

(2) Health related plans

(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional.

(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.

(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.

(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.

(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):

(a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.

(b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.

(c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in

the plan.

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

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

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

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

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

(4) General Nursing Documentation

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

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

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E	Scope and Severity Rating: D
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</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>(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>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 73 of 251 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 #205 & 253) • Basic Health/Orientation (DSP #205) • Person-Centered Planning (1-Day) (DSP #53, 61, 63, 82, 91, 135, 149, 173, 178, 250 & 284) • First Aid (DSP #53, 58, 59, 61, 63, 65, 72, 92, 125, 129, 133, 137, 161, 205, 222, 223, 239, 246, 251, 253, 254, 255, 283, 284 & 289) • CPR (DSP #53, 58, 59, 61, 63, 65, 72, 78, 92, 125, 129, 133, 137, 161, 205, 222, 223, 239, 251, 253, 254, 284 & 289) • Assisting With Medications (DSP #44, 59, 61, 72, 90, 92, 125, 127, 131, 133, 148, 194, 224, 227, 228, 236, 239, 244, 256, 257, 276 & 290) • Rights & Advocacy (DSP #43, 44, 63, 135, 148 & 172) • Level 1 Health (DSP #99, 137, 149, 173, 256, 264 & 268) • Teaching & Support Strategies (DSP #99, 136, 137, 148, 253 & 270) • Positive Behavior Supports Strategies (DSP #82, 99, 101, 137, 173, 177, 179, 251, 253, 264, 267 & 270) 	<p>Repeat Finding</p> <p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 5 of 247 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"> • Person-Centered Planning (1-Day) (DSP #149) • First Aid (DSP #254) • CPR (DSP #254) • Assisting With Medications (DSP #44) • Participatory Communication & Choice Making (DSP #237)

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| | <ul style="list-style-type: none">• Participatory Communication & Choice Making
(DSP #43, 85, 102, 104, 115, 125, 189, 196, 220,
235, 237, 241, 253, 260, 264, 267, 276, 280 &
281) | |
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Tag # 1A22 Staff Competence	Scope and Severity Rating: E	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</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> <ol style="list-style-type: none"> (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDS in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and (5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support 	<p>Based on interview, the Agency failed to ensure that training competencies were met for 9 of 34 Direct Service Personnel.</p> <p>When DSP were asked if they received training on the Individuals ISP, the following was reported:</p> <ul style="list-style-type: none"> • DSP #270 stated, “No, I only been here since July (2008). I’ve been waiting to get trained.” (Individual #24) <p>When DSP were asked if they received training on the Individuals Occupational Therapy Plan, the following was reported:</p> <ul style="list-style-type: none"> • DSP #160 stated, “No, there is a new Occupational Therapist I haven’t gone over the plan yet”. (Per Individual Specific Training section of the ISP, the individual requires an Occupational Therapy Plan) (Individual #7) <p>When DSP were asked if they received training on the Individuals Physical Therapy Plan, the following was reported:</p> <ul style="list-style-type: none"> • DSP #160 stated, “I don’t think he has one because it is not here.” (Per Individual Specific Training section of the ISP, the individual receives Physical Therapy.) (Individual #7) <p>When DSP were asked if they received training on the Individuals Speech Therapy Plan, the following was reported:</p> <ul style="list-style-type: none"> • DSP #273 stated, “No”. (Per Individual Specific Training section of the ISP, the individual receives Speech Therapy.) (Individual #18) <p>When DSP were asked if the individual had a Positive Behavioral Crisis Plan the following was</p>	<p>Complete</p>

<p>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 DDS Statewide Training Database as specified in DDS 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 DDS 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 DDS Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p>	<p>reported:</p> <ul style="list-style-type: none"> • During the on-site visit on 2/14/2009 DSP#268, looked for crisis plans in residence book but could not identify any plans. (Per Individual Specific Training section of the ISP the individual required a Positive Behavioral Crisis Plan) (Individual #5) • DSP #268 stated, "No, if crisis call 911 and the guardian too." (Per Individual Specific Training section of the ISP, the individual has Positive Behavioral Crisis Plan) (Individual #19) • DSP #177 stated, "I don't know." DSP #177, looked in the residence book but could not identify any plans. (Per Agency file review, the individual has Positive Behavioral Crisis Plan). (Individual#10) • DSP #270 stated, "I've haven't been trained". (Per agency file, the individual has Positive Behavioral Crisis Plans.) (Individual #24) <p>When DSP were asked if they received training on the Individuals Meal Time Plans, or Health Care Plans the following was reported:</p> <ul style="list-style-type: none"> • DSP# 72 stated, "No they don't have either one." (Per Individual Specific Training section of the ISP the individual has a Meal Time Protocol for eating equipment and seating, and Health Care Plans for seizures, skin Integrity and aspiration). (Individual #5) <p>When DSP were asked if they received training on the Individuals Health Care Plans, the following was reported:</p> <ul style="list-style-type: none"> • DSP #88 did not respond to the surveyor questions regarding Healthcare Plans for 	
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	<p>Individual #21. (Per ISP the individual has a HAT score of 6 and the Individual Specific Training section of the ISP indicates there are HCPs for: fractures, skin breakdown, depression, hypertension, aspiration, G-tube, risk for infection, urinary incontinence, constipation & diabetes). (Individual #21)</p> <ul style="list-style-type: none"> • DSP #295 stated, "I observe her when walking." (Per review of Agency file, the Individual has health care plans for seizure disorder, constipation, alteration in high and low blood glucose). (Individual #26) <p>When DSP were asked if they received training on the Individuals Crisis Plans, the following was reported:</p> <ul style="list-style-type: none"> • DSP #88 stated "I don't know, I've only been here for two months" when asked specifically if the individual had seizures. (Per Individual Specific Training section of the ISP, has a Seizure Crisis Plan; the individual has a HAT score of 6). (Individual #21) • DSP # 292 stated, "I received no training on his seizure disorder." (Per Agency file review, the individual has a seizure crisis plan; the individual has history of Seizures). (Individual #6) • DSP #295 stated, "She has plans for falling and unsteady gait." (Per agency file, the individual had crisis plans for seizure disorder, edema, hypertension, constipation, and skeletal integrity). (Individual #26) <p>When DSP were asked if the Individual had diabetes, and what are the signs and symptoms for low blood sugar and high blood sugar, the following was reported:</p>	
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- DSP #88 stated, “Decreased level of care, call the nurse, the nurse monitors diabetes.” DSP could not give examples of signs and symptoms of high blood sugar and low blood sugar for diabetes, when asked for specific signs. (Individual #21)

When DSP were asked if they had received training on the individuals Seizure Disorder the following was reported;

- DSP #88 stated, “I had no knowledge of a seizure disorder. I’ve been here for only two months.” (Per Individual Specific Training section of the ISP the individual is required to have a Seizure Crisis Plan). (Individual 21)
- DSP #270 stated, “I haven’t been trained on him, I’ve only been working in this house since July (2008). He did have a seizure in December 2008.” (Per agency file individual has a Seizure Crisis Plan). (Individual # 24)
- DSP #295 stated, “Nothing specific to #26, my dog has seizures so I have to read up on them.” DSP could not identify plan after looking in residence book. (Per ISP, the Individual has Seizure Crisis Plan). (Individual #26)

When DSP were asked, when you need to assist an individual with PRN medication, what are the steps you need to take before assisting with the medication, the following was reported:

- DSP #295 stated, “If you have the Doctor’s orders that’s all you need. I would let nurse know, but I don’t have too.” (Per the Agency’s “Health and Safety-Assisting Consumers with Medication policy and procedures: 3. If a consumer has signs and symptoms of illness at any time during your shift, a. Contact the nurse before assisting

with PRN (over the counter) b. Make a notation in the consumers' medical log that you have contacted the nurse. c. Follow directions on the Comfort Measure form (located in the consumer's medical file"). (Individual# 26)

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D	Scope and Severity Rating: NA
<p>NMAC 7.1.9.9 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:</p> <p>A. homicide; B. trafficking, or trafficking in controlled substances; C. kidnapping, false imprisonment, aggravated assault or aggravated battery; D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; E. crimes involving adult abuse, neglect or financial exploitation; F. crimes involving child abuse or neglect; G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p> <p>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.</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 31 of 259 Agency Personnel.</p> <ul style="list-style-type: none"> • #48 – Date of hire 11/15/2008 • #49 -- Date of hire 7/07/2008 • #63 – Date of hire 2/09/2008 • #70 – Date of hire 9/06/2008 • #74 – Date of hire 6/14/2008 • #94 – Date of hire 5/31/2008 • #99 – Date of hire 4/12/2004 • #102 – Date of hire 8/09/2008 • #114 – Date of hire 5/31/2008 • #125 – Date of hire 6/05/2006 • #128 – Date of hire 5/31/2008 • #135 – Date of hire 10/04/2008 • #140 – Date of hire 2/10/2007 • #154 – Date of hire 8/10/1998 • #155 – Date of hire 8/09/2008 • #158 – Date of hire 8/09/2008 • #160 – Date of hire 8/09/2008 • #161 – Date of hire 11/21/1975 • #166 – Date of hire 11/17/1986 • #181 – Date of hire 4/24/2006 • #184 – Date of hire 5/31/2008 • #195 – Date of hire 8/09/2008 • #211 – Date of hire 7/31/2008 • #214 – Date of hire 5/31/2008 • #223 – Date of hire 4/24/2006 • #234 – Date of hire 8/09/2008 • #242 – Date of hire 9/06/2008 • #253 – Date of hire 1/27/2007 • #263 – Date of hire 1/05/2008 • #268 – Date of hire 7/12/2008 • #283 – Date of hire 7/28/2007 	<p>Complete</p>

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: D	Scope and Severity Rating: D
<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, neglect or exploitation.</p> <p>E. Documentation for other staff. With</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 34 of 259 Agency Personnel.</p> <ul style="list-style-type: none"> • #48 – Date of Hire 11/15/2008 • #49 – Date of Hire 7/07/2008 • #62 – Date of Hire 7/12/2008 • #63 – Date of Hire 2/09/2008 • #69 – Date of Hire 2/24/2007 • #74 – Date of Hire 6/14/2008 • #93 – Date of Hire 7/12/2008 • #111 – Date of Hire 2/09/2008 • #114 – Date of Hire 5/31/2008 • #125 – Date of Hire 6/05/2006 • #128 – Date of Hire 5/31/2008 • #135 – Date of Hire 10/04/2008 • #140 – Date of Hire 2/10/2007 • #143 – Date of Hire 9/22/2007 • #150 – Date of Hire 2/10/2007 • #154 – Date of Hire 8/10/1998 • #155 – Date of Hire 8/09/2008 • #156 – Date of Hire 7/12/2008 • #157 – Date of Hire 1/27/2007 • #166 – Date of Hire 11/17/1986 • #171 – Date of Hire 9/08/2007 • #179 – Date of Hire 7/12/2008 • #183 – Date of Hire 11/06/2006 • #208 – Date of Hire 7/12/2008 • #225 – Date of Hire 9/08/2007 • #242 – Date of Hire 9/06/2008 • #254 – Date of Hire 7/12/2008 • #259 – Date of Hire 2/10/2007 • #260 – Date of Hire 9/08/2007 • #261 – Date of Hire 7/12/2008 • #266 – Date of Hire 7/12/2008 • #268 – Date of Hire 7/12/2008 	<p>New and Repeat Findings</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 1 of 247 Agency Personnel.</p> <ul style="list-style-type: none"> • #308 – Date of Hire 5/30/2009

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.

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.

- #271 – Date of Hire 7/12/2008
- #283 – Date of Hire 7/28/2007

Tag # 1A27 (CoP) Late/Failure/Duty to Report	Scope and Severity Rating: E	Scope and Severity Rating: E
<p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>A. Duty To Report:</p> <p>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</p> <p>(2) All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include: 7.1.13 NMAC 4</p> <p>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</p> <p>(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.</p> <p>(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.</p> <p>B. Notification: (1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.</p>	<p>Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 14 of 36 individuals.</p> <p>Individual #4</p> <ul style="list-style-type: none"> Incident date 9/19/2008. Allegation was abuse exploitation. Report received 9/25/2008. Late Reporting. Report from IMB reported incident was "Confirmed." <p>Individual #5</p> <ul style="list-style-type: none"> Incident date 9/4/2008. Allegation was neglect. Report received 9/8/2008. Late Reporting. Report from IMB reported incident was "Confirmed." <p>Individual #16</p> <ul style="list-style-type: none"> Incident date 11/1/2008. Allegation was neglect. Report received 11/6/2008. Late Reporting. Report from IMB reported incident was "Confirmed." <p>Individual #17</p> <ul style="list-style-type: none"> Incident date 9/15/2008. Allegation was neglect. Report received 9/16/2008. Failure to report. Report from IMB reported incident was "Confirmed." <p>Individual #27</p> <ul style="list-style-type: none"> Incident date 9/19/2008. Allegation was neglect. Report received 9/22/2008. Failure to report. Report from IMB reported incident was "Confirmed." Incident date 9/23/2008. Allegation was abuse. Report received 9/24/2008. Failure to report. Report from IMB reported incident was "Confirmed." 	<p>New and Repeat Finding</p> <p>Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 4 of 23 individuals.</p> <p>Individual #20</p> <ul style="list-style-type: none"> Incident date 8/6/2009. Allegation was neglect. Report received 8/13/2009. Late Reporting. Report from IMB reported incident was "Confirmed." <p>Individual #22</p> <ul style="list-style-type: none"> Incident date 8/6/2009. Allegation was neglect. Report received 8/13/2009. Late Reporting. Report from IMB reported incident was "Confirmed." <p>Individual #30</p> <ul style="list-style-type: none"> Incident date 8/6/2009. Allegation was neglect. Report received 8/13/2009. Late Reporting. Report from IMB reported incident was "Confirmed." <p>Individual #31</p> <ul style="list-style-type: none"> Incident date 9/15/2009. Allegation was exploitation. Report received 9/30/2009. Late Reporting. Report from IMB reported incident was "Confirmed."

	<p>Individual #28</p> <ul style="list-style-type: none"> • Incident date 10/1/2008. Allegation was neglect. Report received 10/10/2008. Late Reporting. Report from IMB reported incident was “Confirmed.” • Incident date 10/6/2008. Allegation was neglect. Report received 10/14/2008. Late Reporting. Report from IMB reported incident was “Confirmed.” <p>Individual #29</p> <ul style="list-style-type: none"> • Incident date 11/1/2008. Allegation was neglect. Report received 11/6/2008. Late Reporting. Report from IMB reported incident was “Confirmed.” <p>Individual #30</p> <ul style="list-style-type: none"> • Incident date 11/25/2008. Allegation was neglect. Report received 11/26/2008. Failure to report. Report from IMB reported incident was “Confirmed.” <p>Individual #31</p> <ul style="list-style-type: none"> • Incident date 11/28/2008. Allegation was neglect. Report received 12/2/2008. Late Reporting. Report from IMB reported incident was “Confirmed.” <p>Individual #32</p> <ul style="list-style-type: none"> • Incident date 12/28/08. Allegation was neglect. Report received 1/5/2009. Late Reporting. Report from IMB reported incident was “Confirmed.” <p>Individual #33</p> <ul style="list-style-type: none"> • Incident date 11/1/2008. Allegation was neglect. Report received 11/6/2008. Late Reporting. Report from IMB reported incident was “Confirmed.” 	
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Individual #34

- Incident date 12/28/2008. Allegation was neglect. Report received 12/31/2008. Failure to report. Report from IMB reported incident was "Confirmed."

Individual #35

- Incident date 12/27/2008. Allegation was neglect. Report received 1/9/2009. Failure to report. Report from IMB reported incident was "Confirmed."

Individual #36

- Incident date 12/27/2008. Allegation was neglect. Report received 1/5/2009. Late Reporting. Report from IMB reported incident was "Confirmed."

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: E	Scope and 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>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>Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 56 of 266 Agency Personnel.</p> <ul style="list-style-type: none"> • Abuse, Neglect & Exploitation Incident Management Training (#40, 44, 53, 59, 60, 61, 64, 70, 84, 88, 95, 97, 98, 104, 108, 113, 117, 125, 127, 129, 130, 149, 156, 157, 164, 166, 169, 173, 174, 182, 188, 189, 210, 212, 213, 217, 223, 231, 233, 236, 237, 239, 243, 244, 255, 259, 270, 271, 288, 290, 299, 300, 301 & 302) <p>When DSP were asked what two State Agencies is suspected Abuse, Neglect and Exploitation reported the following was reported:</p> <ul style="list-style-type: none"> • DSP #177 stated, "Call nurse and coordinator". • DSP #40 stated, "I report to human resources, welfare, administration and the RN". • DSP #110 stated, "I don't know which agencies to report to." When DSP was asked if he could identify an IMB poster. DSP did not have an IMB poster in the home posted. 	<p>New and Repeat Finding</p> <p>Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 10 of 247 Agency Personnel.</p> <ul style="list-style-type: none"> • Abuse, Neglect & Exploitation Incident Management Training (#108, 113, 120, 123, 127, 157, 165, 182, 217 & 239)

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: E	Scope and Severity Rating: NA
<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>F. Posting of Incident Management Information Poster: All licensed health care facilities and community based service providers shall post two (2) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. All licensed health care facilities and community based service providers operating sixty (60) or more beds shall post three (3) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. The posters shall be posted where employees report each day and from which the employees operate to carry out their activities. Each licensed health care facility or community based service provider shall take steps to insure that the notices are not altered, defaced, removed, or covered by other material. [7.1.13.10 NMAC - N, 02/28/06]</p>	<p>Based on observation, the Agency failed to post two (2) or more Incident Management Information posters in a prominent public location for the following locations for 4 of 18 residences:</p> <p>The following locations were identified:</p> <p>Residence of :</p> <ul style="list-style-type: none"> • Individual (#2, 12, 13 & 14) 	<p>Complete</p>

Tag # 1A31 (CoP) Client Rights	Scope and Severity Rating: E	Scope and Severity Rating: NA
<p>NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p>Long Term Services Division Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003</p> <p>IV. POLICY STATEMENT Human Rights Committees are required for</p>	<p>Based on record review the Agency failed to ensure the rights of Individuals was not restricted or limited for 6 of 26 Individuals. (Individual #1, 5, 13, 19, 23 & 24)</p> <p>A review of Agency Individual files found no documentation of Positive Behavior Plans being reviewed at least quarterly if they required approval by the Human Rights Committee.</p> <p>A review of Agency Individual files indicated the following required Human Rights Committee Approval for restrictions. No documentation was found regarding Human Rights Approval for the following:</p> <ul style="list-style-type: none"> • PRN Psychotropic Medications - Ativan. No evidence found in Human Rights Committee notes to determine if approval of PRN was needed. (#1) • Positive Behavior Support Plan Levels Program. The Los Lunas Community Program, "Human Rights Committee Behavior Supports/Crisis Plan Review," states "Review in one year." Per DDSD policy, "Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly." (#5) • PRN Psychotropic Medications – Lorazepam. No evidence found in Human Rights Committee notes to determine if approval of PRN was needed. (#13) • Positive Behavior Support Plan Levels Program. The Los Lunas Community Program, "Human Rights Committee Behavior Supports/Crisis Plan Review," states "Review in one year." Per DDSD policy, "Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly." (#13) 	<p>Complete</p>

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

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

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

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

A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS

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.

- Positive Behavior Support Plan Levels Program. The Los Lunas Community Program, "Human Rights Committee Behavior Supports/Crisis Plan Review," states "Review in one year." Per DDSD policy, "Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly." (#19)
- Positive Behavior Support Plan Levels Program. The Los Lunas Community Program, "Human Rights Committee Behavior Supports/Crisis Plan Review," states "Review in one year." Per DDSD policy, "Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly." (#23)
- PRN Psychotropic Medications – Risperdal. No evidence found in Human Rights Committee notes to determine if approval of PRN was needed. (#24)

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: E	Scope and Severity Rating: NA
<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 17of 26 individuals.</p> <p>Per Individuals ISP's the following was found with regards to the implementation of ISP Outcomes:</p> <p>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <ul style="list-style-type: none"> • None found for 1/2008 - 1/2009 (Individual #5) • None found for 1/2008 - 1/2009 (Individual #7) • None found for 1/2008 - 1/2009 (Individual #10) • None found for 1/2008 - 1/2009 (Individual #12) • None found for 1/2008 - 1/2009 (Individual #16) • None found for 1/2008 - 1/2009 (Individual #19) • None found for 1/2008 - 1/2009 (Individual #20) • None found for 1/2008 - 1/2009 (Individual #23) <p>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <ul style="list-style-type: none"> • None found for 1/2008 - 1/2009 (Individual #1) • None found for 1/2008 - 1/2009 (Individual #3) • None found for 1/2008 - 1/2009 (Individual #8) • None found for 1/2008 - 1/2009 (Individual #9) • None found for 1/2008 - 1/2009 (Individual #11) • None found for 1/2008 - 1/2009 (Individual #26) <p>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <ul style="list-style-type: none"> • Data Collection information from Agency, did not contain Outcomes or Action Steps for the Months of October, November, & December 2008. (Individual #6) • Data Collection information from Agency, did not contain Outcomes or Action Steps for the Months of October, November, & December 2008. 	<p>Complete</p>

	<p>(Individual #12)</p> <ul style="list-style-type: none">• Data Collection information from Agency, did not contain Outcomes or Action Steps for the Months of October, November, & December 2008. (Individual #13)• Data Collection information from Agency, did not contain Outcomes or Action Steps for the Months of October, November, & December 2008. (Individual #14)• Data Collection information from Agency, did not contain Outcomes or Action Steps for the Months of October, November, & December 2008. (Individual #16)• Data Collection information from Agency, did not contain Outcomes or Action Steps for the Months of October, November, & December 2008. (Individual #19)• Data Collection information from Agency, did not contain Outcomes or Action Steps for the Months of October, November, & December 2008. (Individual #20)• Data Collection information from Agency, did not contain Outcomes or Action Steps for the Months of October, November, & December 2008. (Individual #23)	
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Tag # 1A33 Board of Pharmacy - Lic	Scope and Severity Rating: B	Scope and Severity Rating: NA
<p>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual</p> <p>6. Display of License and Inspection Reports</p> <p>A. The following are required to be publicly displayed:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Current Custodial Drug Permit from the NM Board of Pharmacy <input type="checkbox"/> Current registration from the consultant pharmacist <input type="checkbox"/> Current NM Board of Pharmacy Inspection Report 	<p>Based on observation, the Agency failed to provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 4 of 18 residences.</p> <p>Individual Residence:</p> <ul style="list-style-type: none"> • Current Custodial Drug Permit from the NM Board of Pharmacy (#7) • Current NM Board of Pharmacy Inspection report (#7, 12, 13 & 23) 	<p>Complete</p>

Tag # 1A36 SC Training	Scope and Severity Rating: B	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</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 3 of 8 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 #298 & 303) • Person Centered Planning (2-Day) (SC #298) • Promoting Effective Teamwork (SC #298, 300 & 303) • Advocacy Strategies (SC #303) 	<p>Complete</p>

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: E	Scope and Severity Rating: D
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</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>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 104 of 266 Agency Personnel.</p> <ul style="list-style-type: none"> Individual Specific Training (#40, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 54, 55, 56, 57, 58, 59, 60, 61, 63, 68, 70, 71, 72, 80, 81, 82, 84, 86, 87, 92, 99, 100, 102, 104, 105, 106, 111, 112, 125, 137, 140, 148, 149, 156, 162, 163, 167, 168, 169, 170, 173, 175, 178, 183, 194, 198, 206, 208, 209, 215, 216, 217, 220, 221, 222, 223, 232, 236, 243, 244, 246, 247, 248, 250, 251, 252, 253, 255, 256, 257, 258, 261, 262, 264, 265, 266, 271, 272, 273, 275, 276, 283, 285, 298, 299, 300, 301, 302, 303, 304 & 305) 	<p>New and Repeat Findings</p> <p>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 7 of 262 Agency Personnel.</p> <ul style="list-style-type: none"> Individual Specific Training (#266, 283, 309, 311, 314, 316 & 317)

Tag # 5I11 Reporting Requirements	Scope and Severity Rating: B	Scope and Severity Rating: NA
<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> <p>(1) Identification and implementation of a meaningful day definition for each person served;</p> <p>(2) Documentation summarizing the following:</p> <p>(a) Daily choice-based options; and</p> <p>(b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP.</p> <p>(3) Significant changes in the individual's routine or staffing;</p> <p>(4) Unusual or significant life events;</p> <p>(5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs;</p> <p>(6) Record of personally meaningful community inclusion;</p> <p>(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</p> <p>(8) Any additional reporting required by DDSD.</p>	<p>Based on record review, the Agency failed to complete quarterly reports as required for 4 of 20 individuals receiving Community Inclusion services.</p> <p>Adult Habilitation Quarterly Reports</p> <ul style="list-style-type: none"> • Individual #4 - None found for 1/2008 - 1/2009 • Individual #12 - None found for 1/2008 - 1/2009 • Individual #20 - None found for 1/2008 - 1/2009 • Individual #23 - None found for 1/2008 - 1/2009 	<p>Complete</p>

Tag # 5I25 SE Reimbursement	Scope and Severity Rating: A	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</p> <p>E. Reimbursement</p> <p>(1) Billable Unit:</p> <p>(a) Job Development is a single flat fee unit per ISP year payable once an individual is placed in a job.</p> <p>(b) The billable unit for Individual Supported Employment is one hour with a maximum of four hours a month. The Individual Supported Employment hourly rate is for face-to-face time which is supported by non face-to-face activities as specified in the ISP and the performance based contract as negotiated annually with the provider agency. Individual Supported Employment is a minimum of one unit per month. If an individual needs less than one hour of face-to-face service per month the IDT Members shall consider whether Supported Employment Services need to be continued. Examples of non face-to-face services include:</p> <p>(i) Researching potential employers via telephone, Internet, or visits;</p> <p>(ii) Writing, printing, mailing, copying, emailing applications, resume, references and corresponding documents;</p> <p>(iii) Arranging appointments for job tours, interviews, and job trials;</p> <p>(iv) Documenting job search and acquisition progress;</p> <p>(v) Contacting employer, supervisor, co-workers and other IDT team members to assess individual's progress, needs and satisfaction; and</p> <p>(vi) Meetings with individual surrounding job development or retention not at the employer's site.</p> <p>(c) Intensive Supported Employment services are intended for individuals who need one-to-one,</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 1 of 4 individuals.</p> <p>Individual #18</p> <ul style="list-style-type: none"> December 2008 - Agency billed 23 units of Supported Employment. Documentation received accounted for 19 units. 	<p>Complete</p>

<p>face-to-face support for 32 or more hours per month. The billable unit is one hour.</p> <p>(d) Group Supported Employment is a fifteen-minute unit.</p> <p>(e) Self-employment is a fifteen minute unit.</p> <p>(4) Billable Activities include:</p> <p>(a) Activities conducted within the scope of services;</p> <p>(b) Job development and related activities for up to ninety (90) calendar days) that result in employment of the individual for at least thirty (30) calendar days; and</p> <p>(c) Job development services shall not exceed ninety (90) calendar days, without written approval from the DDSD Regional Office.</p>		
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Tag # 5144 AH Reimbursement	Scope and Severity Rating: B	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 XVI. REIMBURSEMENT</p> <p>A. Billable Unit. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care.</p> <p>B. Billable Activities</p> <p>(1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours.</p> <p>(2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 8 of 20 individuals.</p> <p>Individual #2</p> <ul style="list-style-type: none"> October 2008 Agency billed 137 units of Adult Habilitation. Documentation received accounted for 130.2 units. <p>Individual #4</p> <ul style="list-style-type: none"> October 2008 Agency billed 409 units of Adult Habilitation. Documentation received accounted for 341 units. November 2008 Agency billed 318 units of Adult Habilitation. Documentation received accounted for 279 units. December 2008 Agency billed 270 units of Adult Habilitation. Documentation received accounted for 228 units. <p>Individual #11</p> <ul style="list-style-type: none"> October 2008 Agency billed 494 units of Adult Habilitation. Documentation received accounted for 377 units. <p>Individual #15</p> <ul style="list-style-type: none"> November 2008 Agency billed 578 units of Adult Habilitation. Documentation received accounted for 156 units. <p>Individual #14</p> <ul style="list-style-type: none"> October 2008 Agency billed 179 units of Adult Habilitation. Documentation received accounted for 159 units. <p>Individual #18</p>	<p>Complete</p>

	<ul style="list-style-type: none">• October 2008 Agency billed 155 units of Adult Habilitation. Documentation received accounted for 135 units. <p>Individual #20</p> <ul style="list-style-type: none">• November 2008 Agency billed 322 units of Adult Habilitation. Documentation received accounted for 244 units. <p>Individual #22</p> <ul style="list-style-type: none">• October 2008 Agency billed 346 units of Adult Habilitation. Documentation received accounted for 328 units.	
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Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: D	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES</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>Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 2 of 8 individuals.</p> <ul style="list-style-type: none"> • Family Living (Annual Update) Home Study (#26) 	<p>Complete</p>

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: D	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</p> <p>G. Health Care Requirements for Community Living Services.</p> <p>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first.</p> <p>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <p>(a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p>	<p>Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 4 of 26 individuals receiving Community Living Services.</p> <ul style="list-style-type: none"> • Annual Physical (#24) • Bone Density Examination (Per Agency file, the exam was completed. No evidence found of exam. (#1) • Auditory Exam (#9) <ul style="list-style-type: none"> ◦ Individual #9 - Per Agency file, last exam was completed 10/2005. Per auditory exam document, exam is to be completed annually. • Abnormal Involuntary Movement Screening/Tardive Dyskinesia (#1) 	<p>Complete</p>

<p>b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.</p> <p>(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <ul style="list-style-type: none"> (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine). 		
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Tag # 6L14 Residential Case File	Scope and Severity Rating: E	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>(8) Progress notes documenting implementation of a</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 18 of 26 Individuals receiving Family Living Services or Supported Living Services.</p> <ul style="list-style-type: none"> • Annual ISP (#2, 11, 13 & 23) • ISP Signature Page (#2, 3, 5, 6, 7, 10, 11, 12, 13, 14, 16, 19, 23, 24 & 26) • Addendum A (#2, 3, 5, 6, 7, 10, 11, 12, 13, 14, 15, 19, 22, 23, 24 & 26) • Individual Specific Training (Addendum B) (#2, 11 & 13) • Positive Behavioral Plan (#7) • Positive Behavioral Crisis Plan (7 & 19) • Special Health Care Needs <ul style="list-style-type: none"> ◦ Meal Time Plan (#2 & 5) • Health Assessment Tool (#7 & 14) • Health Care Plans <ul style="list-style-type: none"> ◦ Allergies (#2) ◦ Swallowing (#14) ◦ Seizures (#14) ◦ Night tremors (#14) ◦ Skin Integrity (#14) ◦ Cognitive ability (#14) ◦ Constipation (#14) • Crisis Plan <ul style="list-style-type: none"> ◦ Cardiac Condition (#19) ◦ Allergies (#19) ◦ Constipation(#13) ◦ Skeletal Integrity (#13) 	<p>New and Repeat findings</p> <p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 4 of 22 Individuals receiving Family Living Services or Supported Living Services.</p> <ul style="list-style-type: none"> • ISP Signature Page (#5) • Addendum A (#5) • Positive Behavioral Crisis Plan (#7) • Health Assessment Tool (#7) • Crisis Plan <ul style="list-style-type: none"> ◦ Cardiac Condition (#19) ◦ Aspiration(#14) ◦ Allergies (#19) ◦ Gastrointestinal (#14) ◦ Constipation(#14) ◦ Respiratory Distress (#14) ◦ Skeletal Integrity (#14)

<p>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, environmental, medications), status of routine adult health care screenings, immunizations, hospital</p>	<ul style="list-style-type: none"> ◦ Violence to self and others (#13) ◦ Head injury (#13) ◦ Poisoning (#13) <ul style="list-style-type: none"> • Data Collection/Data Tracking (#10 & 11) • Progress Notes written by DSP and/or Nurses (#7 & 14) • Health Care Providers Written Orders (#10) • Record of visits of healthcare practitioners (#12) 	
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discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.

Tag # 6L17 Reporting Requirements	Scope and Severity Rating: B	Scope and Severity Rating: NA
<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 5 of 26 individuals receiving Community Living Services.</p> <p>Supported Living Quarterly Reports</p> <ul style="list-style-type: none"> • Individual #5- None found from 1/2008 - 1/2009 • Individual #12 - None found from 10/2008 - 12/2008 • Individual #20 - None found from 1/2008 - 1/2009 • Individual #23 - None found from 1/2008 - 2/2008 <p>Family Living Quarterly Reports</p> <ul style="list-style-type: none"> • Individual #9 - None found from 1/2008 - 1/2009 	<p>Complete</p>

Tag # 6L25 (CoP) Residential Reqts.	Scope and Severity Rating: E	Scope and Severity Rating: D
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS 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 4 of 18 Supported Living and Family Living residences.</p> <p>The following items were no found, not functioning or incomplete:</p> <ul style="list-style-type: none"> • Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#25) • 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 (#20 & 22) • 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 (#20, 22 & 23) 	<p>Repeat Findings</p> <p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 1 of 15 Supported Living and Family Living residences.</p> <p>The following items were no found, not functioning or incomplete:</p> <ul style="list-style-type: none"> • 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 (#23)

Tag # 6L27 FL Reimbursement	Scope and Severity Rating: A	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES</p> <p>B. Reimbursement for Family Living Services</p> <p>(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.</p> <p>(2) Billable Activities shall include:</p> <ul style="list-style-type: none"> (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. <p>(3) Non-Billable Activities shall include:</p> <ul style="list-style-type: none"> (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. 	<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 1 of 8 individuals.</p> <p>Individual #6</p> <ul style="list-style-type: none"> • November 2008 Agency billed 30 units of Family Living. Documentation received accounted for 21 units. Individual was on a trip & not present in the State from Nov 23 -Dec 2, 2008. Notes indicated FLP dropped off the individual at the airport on 11/22 and the respite provider picked the individual up on 12/2/2008. • December 2008 Agency billed 31 units of Family Living. Documentation received accounted for 21 units. Individual was on a trip & not present in the State from Dec 21 -28, 2008. Notes indicated FLP dropped off the individual at the airport on 12/20 and picked the individual up from the airport on 12/29/2008. 	<p>Complete</p>

Date: February 10, 2010

To: Anita Westbrook, Executive Director of the Office of Facilities Management
Provider: Los Lunas Community Program/NMDOH
Address: 445 Camino Del Ray SW, Suite A
State/Zip: Los Lunas, New Mexico, 87031

Region: Metro
Original Survey Date: February 23 - 27, 2009
Verification Survey Date: November 2 - 4, 2009
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation, Supported Employment & Community Access)

Survey Type: Verification Survey

RE: Request for an Informal Reconsideration of Findings

Dear Ms. Westbrook,

Your request for a Reconsideration of Findings was received on January 25, 2010. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable DDSD standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag #: 1A15

Determination: The IRF committee is upholding the original finding in the report. You are required to complete your Plan of Correction as previously indicated. Based on information supplied by your agency, it appears no action was requested regarding the ISP in question until after the verification survey took place. Although a Healthcare Plan (HCP) for an Individual with a Health Assessment Tool (HAT) score of less than 4 is not required "Healthcare Plan" was checked in the Individual Specific Training section of the ISP.

Regarding Tag #: 1A20

Determination: The IRF committee is modifying the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Trainings originally noted under tag number 1A20 for staff #149 (ISP training) and #254 (CPR/First Aid) will be removed. Trainings for staff #44 will be upheld. The documentation supplied by your agency as proof staff #44 does not work directly with Individuals being served is not sufficient as it clearly

states under job assignment 1, "...supporting people in supported employment, day habilitation and community access." Furthermore, under job assignment 3, it states, "Attend and participate in required trainings and meetings for consumers..."

Regarding Tag #: 6L14

Determination: The IRF committee is modifying the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Deficiencies noted in tag number 6L14 regarding Individuals #5 and #7 will be removed from the original report. The deficiency noted for Individual #19 will be upheld. During the on-site survey the Individual's ISP stated a crisis plan for a cardiac condition was required. During the residential site visit staff were asked for the documentation of this plan; Rhonda Benevidez signed the field tool on 11/2/09 at 5:45 PM, noting she was unable to find the plan.

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

Thank you.

Respectfully,



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

CC:
File
DHI
DDSD

Date: February 12, 2010

To: Anita Westbrook, Executive Director of the Office of Facilities Management
Provider: Los Lunas Community Program/NMDOH
Address: 445 Camino Del Ray SW, Suite A
State/Zip: Los Lunas, New Mexico, 87031

Region: Metro

Original Survey Date: February 23 - 27, 2009

Verification Survey Date: November 2 - 4, 2009

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation, Supported Employment & Community Access)

Survey Type: Verification Survey

RE: Request for an Informal Reconsideration of Findings

Dear Ms. Westbrook,

Your second request for a Reconsideration of Findings was received on February 2, 2010. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable DDSD standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag #: 1A09 (Medication Delivery MAR)

Determination: The IRF committee is modifying the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documents received for review deficiencies noted for Individuals #1, 3, 8, 9, 21 and 25 starting on page 11 of the report of deficiencies will be removed. The deficiency noted for Individual #11 will be upheld. Based on the signature of staff, Monica Jaramillo on 11/3/09 at 4:45 PM; affirming she was asked for and could not locate the physician's orders when asked. The modification of this finding will not change the scope and severity rating received from "E," (9* of 21 Individuals).

* note, Your agency was cited for multiple reasons for Individual #21; only a portion of the finding was removed, thus your agency remains deficient in other MAR related areas in regards to Individual #21.

Regarding Tag #: 1A37 (Individual Specific Training)

Determination: The IRF committee is modifying the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documents received for review deficiencies noted for staff #309, 311, 314, 316 and 317 on page 50 of the report of deficiencies will be removed. The deficiency noted for staff #1266 and 283 will be upheld as no documents were received for review disputing the original finding. The modification of this finding will not change the scope and severity rating received from "D," (2 of 262 Agency Personnel).

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

Thank you.

Respectfully,



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

CC:
File
DHI
DDSD