



Alfredo Vigil, MD
Secretary

DEPARTMENT OF

Building a Healthy New Mexico!

Bill Richardson, Governor

Katrina Hotrum
Deputy Secretary

Jessica Sutin
Deputy Secretary

Michael Mulligan
Acting Deputy Secretary

Karen Armitage, MD
Chief Medical Officer

Date: June 23, 2010

To: Darlene Barela, Acting Director
Provider: Mosaic, Inc.
Address: 920 Lobo Canyon Rd. Suite 2A
State/Zip: Grants, New Mexico 87020

E-Mail Address: darlene.barela@mosaicinfo.org

CC: Linda Timmons, President and Chief Executive Officer
Address: 4980 118th Street
State/Zip: Omaha, Nebraska 68137-2220

Region: Northwest – Grants, New Mexico
Original Survey Date: August 17 - 20, 2009
Verif. Survey Date: May 17 - 18, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Survey Type: Verification
Team Leader: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Florie Alire, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Barela,

The Division of Health Improvement/Quality Management Bureau has completed a verification 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 August 17 - 20, 2009.

These findings will be reviewed by the DOH – Internal Review Committee during an upcoming review meeting. You will be contacted by the Department for further instructions regarding your plan of correction requirements.

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,

Tony Fragua, BFA

Tony Fragua
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

“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 – Mosaic, Inc. (Grants) - NW Region - May 17 - 18, 2010

Survey Report #: Q10.01.95338233.NW(GRANTS).001.RTN.01

Survey Process Employed:

Entrance Conference Date: May 17, 2010

Present: **Mosaic Inc.**
Darlene Barela, Interim Director

DOH/DHI/QMB
Nadine Romero, LBSW, Healthcare Surveyor
Florie Alire, RN, Healthcare Surveyor
Deb Russell, BS, Healthcare Surveyor

Exit Conference Date: May 18, 2010

Present: **Mosaic Inc.**
Darlene Barela, Interim Director
Enrique Martinez, Program Coordinator
Christina Robinson, RN
Kelli Niswender, Financial Director
April Nichols, Family living/Supported Living Manager
Michael Maria, Day Program Manager
Gladis Salcido, Day Program Coordinator

DOH/DHI/QMB
Nadine Romero, LBSW, Healthcare Surveyor
Scott Good, MRC, Deputy Bureau Chief, QMB
Florie Alire, RN, Healthcare Surveyor
Deb Russell, BS, Healthcare Surveyor

Homes Visited Number: 6

Administrative Locations Visited Number: 1

Total Sample Size Number: 7

- 1 - Jackson Class Members
- 6 - Non-Jackson Class Members
- 3 - Supported Living
- 4 - Family Living
- 7 - Adult Habilitation
- 3 - Supported Employment
- 3 - Community Access

Records Reviewed (Persons Served) Number: 7

Administrative Files Reviewed

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

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

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)		
	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.

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

Introduction:

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

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

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

The following limitations apply to the IRF process:

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

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

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

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

Administrative Review Process:

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

Regarding IRC Sanctions:

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

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

Agency: Mosaic, Inc. (Grants) – Northwest Region
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Verification Survey
Original Survey Date: August 17 - 20, 2009
Verification Survey Date: May 17 - 18, 2010

Statute	August 17 - 20, 2009 Deficiencies	May 17 - 18, 2010 Verification Survey - New and Repeat Deficiencies
<p>Tag # 1A08 Agency Case File</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</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>Scope and Severity Rating: B</p> <p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 5 of 8 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"> • ISP Signature Page (#8) • Addendum A (#2 & 5) • Speech Therapy Plan (#2, 7 & 8) • Physical Therapy Plan (#1) 	<p>Scope and Severity Rating: N/A</p> <p>Complete</p>

- and telephone number, and health plan if appropriate;
- (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);
 - (3) Progress notes and other service delivery documentation;
 - (4) Crisis Prevention/Intervention Plans, if there are any for the individual;
 - (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: F	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 	<p>Medication Administration Records (MAR) were reviewed for the months of April, May, June & August 2009.</p> <p>Based on record review, 7 of 7 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #1 April 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> Tegretol 400mg (2 times daily) Lamectal (2 times daily) Calcium 600mg (2times daily) Fosamax 70mg (1 time daily) <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> Lamectal (2 times daily) <p>Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> Tegretol 400mg (2 times daily) Lamectal (2 times daily) Calcium 600mg (2times daily) Fosamax 70mg (1 time daily) <p>May 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> Tegretol 400mg (2 times daily) Lamectal (2 times daily) Calcium 600mg (2times daily) 	<p>New & Repeat Findings:</p> <p>Medication Administration Records (MAR) were reviewed for the months of February & March 2010.</p> <p>Based on record review, 3 of 7 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #2 February 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> Erthromycin eye ointment (1 time daily) – Blank 2/7, 12 & 14 (4 PM) <p>March 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> Claritin 10mg (1 time daily) <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> Erthromycin eye ointment (1 time daily) – Blank 3/26 & 28 (4 PM) <p>Individual #4 March 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> Depakote EC 500mg (3 times daily) – Blank 3/14 (12 PM) <p>Individual #8 March 2010 Medication Administration Records contained</p>

<p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff 	<ul style="list-style-type: none"> • Fosamax 70mg (1 time daily) <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Lamectal (2 times daily) <p>Medication Administration Record did not contain the time the medication should be given. MAR indicated time as "AM and/or PM":</p> <ul style="list-style-type: none"> • Tegretol 400mg (2 times daily) • Lamectal (2 times daily) • Calcium 600mg (2times daily) • Fosamax 70mg (1 time daily) <p>June 2009</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Tegretol 400mg (2 times daily) • Lamectal (2 times daily) • Calcium 600mg (2times daily) • Fosamax 70mg (1 time daily) <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Lamectal (2 times daily) <p>Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Tegretol 400mg (2 times daily) • Lamectal (2 times daily) • Calcium 600mg (2times daily) • Fosamax 70mg (1 time daily) <p>Individual #2 May 2009</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is</p>	<p>missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Magnesium Oxide 400mg (1 time daily) – Blank 3/7 (4 PM) • Clorazepate 3.75mg (2 times daily) – Blank 3/5 & 26 (4 PM)
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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>prescribed:</p> <ul style="list-style-type: none"> • Fosamax 70mg (1 time weekly) <p>As indicated by the Medication Administration Records the individual is to take Bisacodyl 5mg (2 times daily). According to the Physician's Orders, Bisacodyl 5mg is to be taken 1 time daily Medication Administration Record & Physician's Orders do not match.</p> <p>June 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Fosamax 70mg (1 time weekly) • Calcium Citrate (1 time daily) <p>As indicated by the Medication Administration Records the individual is to take Bisacodyl 5mg (2 times daily). According to the Physician's Orders, Bisacodyl 5mg is to be taken 1 time daily Medication Administration Record & Physician's Orders do not match.</p> <p>Individual #3 April 2009 During on-site survey Medication Administration Records were requested for months of April, May, and June 2009. As of August 20, 2009, Medication Administration Records for April 2009 were not provided.</p> <p>May 2009 Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Levothyrine 50mg (1 time daily) <p>Medication Administration Records did not contain the diagnosis for which the medication is</p>	
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	<p>prescribed:</p> <ul style="list-style-type: none"> • Levothyrine 50mg (1 time daily) <p>June 2009</p> <p>Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Levothyrine 50mg • Levothyrine 75mg (1 time daily) <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Levothyrine 50mg • Levothyrine 75mg (1 time daily) <p>Medication Administration Records did not contain the frequency of the medication, which is to be given:</p> <ul style="list-style-type: none"> • Levothyrine 50mg <p>During on-site survey (August 17 - 20, 2009) Physician Orders were requested. As of (8/20/2009), Physician Orders had not been provided.</p> <p>Individual #4</p> <p>April 2009</p> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Colace 100mg (1 time daily) – Blank 4/07 (5PM) <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Colace 100mg (1 time daily) <p>May 2009</p> <p>Medication Administration Records contained</p>	
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	<p>missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Oyster Calcium D 500mg (1 time daily) – Blank 5/29 (8AM) <p>June 2009</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Miralax 1 tsp (1 time daily) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Miralax 1 tsp (1 time daily) <p>Individual #5</p> <p>April 2009</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Paroxetine 30mg (1 time daily) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Miralax 1 tsp (1 time daily) <p>May 2009</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Paroxetine 30mg (1 time daily) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Paroxetine 30mg (1 time daily) <p>Medication Administration Record did not contain the time the medication should be given.</p> <ul style="list-style-type: none"> • Paroxetine 30mg (1 time daily) 	
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	<p>June 2009</p> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Paroxetine – Blank 6/1, 2, 3, 4, 5, 6 & 7. (MAR did not indicate the time the medication was given) <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Paroxetine <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Paroxetine <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Paroxetine <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> • Paroxetine <p>Medication Administration Record did not contain the time the medication should be given.</p> <ul style="list-style-type: none"> • Paroxetine <p>Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Paroxetine <p>During on-site survey (August 17 - 20, 2009) Physician Orders were requested. As of (8/20/2009), Physician Orders had not been provided.</p>	
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	<p>Individual #6 April 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Trazodone 100mg (1 time daily) • Carbamazepine 100mg (3 times daily) • Buspirone HCL 10mg (3 times daily) <p>Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Trazodone 100 mg (1 time daily) • Carbamazepine 100mg (3 times daily) • Buspirone HCL 10mg (3 times daily) <p>May 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Trazodone 100 mg (1 time daily) • Carbamazepine 100mg (3 times daily) • Buspirone HCL 10mg (3 times daily) <p>Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Trazodone 100 mg (1 time daily) • Carbamazepine 100mg (3 times daily) • Buspirone HCL 10mg (3 times daily) <p>June 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Trazodone 100 mg (1 time daily) • Carbamazepine 100mg (3 times daily) 	
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	<ul style="list-style-type: none"> • Buspirone HCL 10mg (3 times daily) <p>Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:</p> <ul style="list-style-type: none"> • Trazodone 100 mg (1 time daily) • Carbamazepine 100mg (3 times daily) • Buspirone HCL 10mg (3 times daily) <p>Individual #8 May 2009</p> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Prenatal Plus (1 time daily) – Blank 5/22 (8AM) • Tegretol 200mg (2 times daily) – Blank 5/23 (5PM) <p>June 2009</p> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Elavil 100mg (1 time daily) – Blank 5/16 (5PM) 	
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Tag # 1A09 Medication Delivery - PRN Medication	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 	<p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 4 of 7 Individuals.</p> <p>Individual #1 April 2009</p> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Correctol <p>Medication Administration Records did not contain the circumstance for which the medication is to be given:</p> <ul style="list-style-type: none"> • Correctol <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Correctol <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"> • Correctol <p>May 2009</p> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Correctol <p>Medication Administration Records did not contain the circumstance for which the medication is to be given:</p> <ul style="list-style-type: none"> • Correctol <p>Medication Administration Records did not contain the route of administration for the following medications:</p>	<p>New & 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 2 of 7 Individuals.</p> <p>Individual #2 March 2010</p> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Tylenol Extra Strength (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Tylenol Extra Strength (PRN) <ul style="list-style-type: none"> • Tussin CF (PRN) <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Tylenol Extra Strength (PRN) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Tylenol Extra Strength – PRN – 3/11 & 12 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Tylenol Extra Strength – PRN – 3/11 & 12 (given 1 time) <p>Individual #3 February 2010</p> <p>Medication Administration Records did not contain the circumstance for which the medication is to be</p>

<p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued 	<ul style="list-style-type: none"> • Correctol <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"> • Correctol <p>June 2009</p> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Correctol <p>Medication Administration Records did not contain the circumstance for which the medication is to be given:</p> <ul style="list-style-type: none"> • Correctol <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Correctol <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"> • Correctol <p>Individual #2 April 2009</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"> • Erythromycin Ointment (3 times daily) <p>No Effectiveness was noted on the Medication Administration Record for the following medication:</p> <ul style="list-style-type: none"> • Erythromycin Ointment (3 times daily) – 4/1, 2, 3 & 4 (given 3 times daily); 4/6, 7, 8, 9 & 10 (given 3 times daily); 4/13, 14, 15, 16, 17 & 18 (given 3 	<p>used:</p> <ul style="list-style-type: none"> • Mometasone Furoate Cream (PRN)
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<p>or changed;</p> <p>(x) The name and initials of all staff administering medications.</p> <p>Model Custodial Procedure Manual D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> ➤ symptoms that indicate the use of the medication, ➤ exact dosage to be used, and ➤ the exact amount to be used in a 24 hour period. <p>Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006 F. PRN Medication 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.</p>	<p>times daily); 4/20 & 21 (given 3 times daily); 4/23, 24 & 25 (given 3 times daily) & 4/27, 28, 29 & 30 (given 1 time daily)</p> <p>No Signs/Symptoms were noted on the Medication Administration Record for the following medication:</p> <ul style="list-style-type: none"> • Erythromycin Ointment– 4/1, 2, 3 & 4 (given 3 times daily); 4/6, 7, 8, 9 & 10 (given 3 times daily); 4/13, 14, 15, 16, 17 & 18 (given 3 times daily); 4/20 & 21 (given 3 times daily); 4/23, 24 & 25 (given 3 times daily) & 4/27, 28, 29 & 30 (given 1 time daily) <p>May 2009 Medication Administration Records did not contain the circumstance for which the medication is to be given:</p> <ul style="list-style-type: none"> • Erythromycin Ointment – (PRN) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Erythromycin Ointment – PRN – 5/1 & 2 (given 3 times daily); 5/4 & 5 (given 3 times daily); 5/7, 8 & 9 (given 3 times daily); 5/11, 12, 13, 14, 15, 16 (given 3 times daily); 5/17, 18, 19, 20, 21 (given 3 times daily) & 5/26 (given 3 times daily) • Dimetapp – PRN - 5/1 (given 1 time daily); 5/2 (given 2 times daily); 5/3 (given 1 time daily); 5/4 & 5/5 (given 2 times daily) 5/6 (given 1 time daily); 5/7 (given 2 times daily); 5/8 (given 1 time daily) & 5/11 (given 1 time daily) <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Erythromycin Ointment – PRN – 5/1 & 2 (given 3 times daily); 5/4 & 5 (given 3 times daily); 5/7, 8 & 9 (given 3 times daily); 5/11, 12, 13, 14, 15, 16 (given 3 times daily); 5/17, 18, 19, 20, 21 (given 3 times daily) & 5/26 (given 3 times daily) 	
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4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy).

H. Agency Nurse Monitoring

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

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

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

- Dimetapp - PRN - 5/3 (given 1 time daily); 5/4 & 5/5 (given 2 times daily) 5/6 (given 1 time daily); 5/7 (given 2 times daily); 5/8 (given 1 time daily) & 5/11 (given 1 time daily)

June 2009

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

- Erythromycin Ointment – PRN

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

- Erythromycin Ointment – PRN – 6/1- 6/12 (given 3 times daily); 6/15 - 6/25 (given 3 times daily); 6/27 (given 3 times daily) & 6/29 & 30 (given 3 times daily)

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

- Erythromycin Ointment – PRN – 6/1- 6/12 (given 3 times daily); 6/15 - 6/25 (given 3 times daily); 6/27 (given 3 times daily) & 6/29 & 30 (given 3 times daily)

Individual #5

June 2009

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

- Aspirin

Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard:

- Aspirin

Medication Administration Record document did not

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

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

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

contain the following information: the symptoms that indicate the use of the medication.

Medication Administration Record document did not contain the following information: the effectiveness that indicate the results of the medication

Medication Administration Record document did not contain the following information: the exact amount to be used in a 24-hour period

Individual #8

May 2009

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

- Colace 150mg/15ml (PRN)

June 2009

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

- Colace 150mg/15ml (PRN)

Tag # 1A09 Medication Delivery - PRN Nurse Approval	Scope and Severity Rating: D	Scope and Severity Rating: N/A
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>E. Medication Delivery...</p> <p>Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006</p> <p>F. PRN Medication</p> <p>3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.</p> <p>4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating</p>	<p>Based on record review, the Agency failed to maintain documentation of PRN usage as required by standard for 1 of 7 Individuals.</p> <p>Individual #2 May 2009 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication:</p> <ul style="list-style-type: none"> • Erythromycin Ointment – PRN – 5/1 & 2 (given 3 times daily); 5/4 & 5 (given 3 times daily); 5/7, 8 & 9 (given 3 times daily); 5/11, 12, 13, 14, 15, 16 (given 3 times daily); 5/17, 18, 19, 20, 21 (given 3 times daily) & 5/26 (given 3 times daily) • Dimetapp - PRN - 5/1 (given 1 time daily); 5/2 (given 2 times daily); 5/3 (given 1 time daily); 5/4 & 5 (given 2 times daily) 5/6 (given 1 time daily); 5/7 (given 2 times daily); 5/8 (given 1 time daily) & 5/11 (given 1 time daily) <p>June 2009 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: Erythromycin Ointment – PRN – 6/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 & 12 (given 3 times daily); 6/15, 16, 17, 18, 19, 20, 21, 22, 23, 24 & 25 (given 3 times daily); 6/27 (given 3 times daily)& 6/29 & 30 (given 3 times daily)</p>	<p>Complete</p>

use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy).

H. Agency Nurse Monitoring

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

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

C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic

Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).

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

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

NMAC 16.19.11.8 MINIMUM STANDARDS:

A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:

(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications**. This documentation shall include:

- (i) Name of resident;
- (ii) Date given;
- (iii) Drug product name;
- (iv) Dosage and form;
- (v) Strength of drug;
- (vi) Route of administration;
- (vii) How often medication is to be taken;
- (viii) Time taken and staff initials;
- (ix) Dates when the medication is discontinued or changed;
- (x) The name and initials of all staff administering medications.

Tag # 1A11 (CoP) Transportation P&P	Scope and Severity Rating: F	Scope and Severity Rating: N/A
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>G. Transportation: Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety". The policy and procedures must address at least the following topics:</p> <ol style="list-style-type: none"> (1) Drivers' requirements, (2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions, (3) Vehicle maintenance and safety inspections, (4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures, (5) Emergency Plans, including vehicle evacuation techniques, (6) Documentation, and (7) Accident Procedures. <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Training Requirements for Direct Service Agency Staff Policy...</p>	<p>Based on record review, the Agency failed to have a written policies and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals.</p> <p>Review of Agency's policies and procedures indicated the following elements were not found:</p> <p>(3) Vehicle maintenance and safety inspections,</p>	<p>Complete</p>

Tag # 1A11 (CoP) Transportation 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 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. - G. Transportation:...</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff Date: March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <p>1. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:</p> <ol style="list-style-type: none"> 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency) 	<p>Based on record review, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 16 of 35 Direct Service Personnel.</p> <p>No documented evidence was found of the following required training:</p> <ul style="list-style-type: none"> • Transportation (DSP #50, 55, 58, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73 & 74) 	<p>Repeat Findings:</p> <p>Based on record review, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 3 of 30 Direct Service Personnel.</p> <p>No documented evidence was found of the following required training:</p> <ul style="list-style-type: none"> • Transportation (DSP #55, 58 & 62)

Tag # 1A12 Reimbursement/Billable Units	Scope and Severity Rating: B	Scope and Severity Rating: B
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</p> <p>B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <ol style="list-style-type: none"> (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</p> <p>Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed, which contained the required information for 4 of 8 individuals.</p> <p>Individual #1 April 2009</p> <ul style="list-style-type: none"> • The Agency billed 22 units of Family Living on 4/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 & 17; 4/21, 22 & 23 & 4/28, 29 & 30, 2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. <p>Individual #3 June 2009</p> <ul style="list-style-type: none"> • The Agency billed 24 units of Adult Habilitation on 6/12/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. <p>Individual #5 April 2009</p> <ul style="list-style-type: none"> • The Agency billed a total of 21 hours of Supported Employment on 4/2/2009 through 4/23/2009. Documentation on 4/2, 4, 8, 21, 22 & 23 did not contain start and end time to justify billing. <p>Individual #7 April 2009</p> <ul style="list-style-type: none"> • The Agency billed 30 units of Family Living on 4/01/2009 through 4/30/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. • The Agency billed a total of 56 hours of Supported Employment in April 2009. Documentation on 4/1, 2, 7, 8, 9, 14, 15, 16, 21, 22 & 23, 2009 did not contain a signature/authenticated name of the staff providing the service to justify billing. 	<p>New & Repeat Findings:</p> <p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed, which contained the required information for 4 of 7 individuals.</p> <p>Individual #1 March 2010</p> <ul style="list-style-type: none"> • The Agency billed 27 units of Family Living from 3/1/2010 through 3/31/2010. Documentation on 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 29, 30 & 31/2010 did not contain start and end time to justify billing. <p>Individual #3 March 2010</p> <ul style="list-style-type: none"> • The Agency billed a total of 28 hours of Family Living on 3/01/2010 through 3/31/2010. Documentation on 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31/2010 did not contain start and end time to justify billing. <p>Individual #6 March 2010</p> <ul style="list-style-type: none"> • The Agency billed a total of 28 hours of Family Living on 3/01/2010 through 3/31/2010. Documentation on 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31/2010 did not contain start and end time to justify billing. <p>Individual #7 March 2010</p> <ul style="list-style-type: none"> • The Agency billed a total of 28 hours of Family Living on 3/01/2010 through 3/31/2010. Documentation on 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31/2010 did not contain start and end time to justify billing.

	<p>May 2009</p> <ul style="list-style-type: none">• The Agency billed 31 units of Family Living on 5/1/2009 through 5/31/2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing.• The Agency billed a total of 44 hours of Supported Employment on 5/5/2009 through 5/27/2009. Documentation on 5/12, 13, 14, 19, 20, 21, 26 & 27 did not contain a signature/authenticated name of the staff providing the service to justify billing.	
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Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: E	Scope and Severity Rating: N/A
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>(1) Documentation of nursing assessment activities...</p> <p>(2) Health related plans</p> <p>(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional.</p> <p>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.</p> <p>(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.</p> <p>(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.</p> <p>(3) For all individuals with a HAT score of 4, 5 or 6,</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 2 of 8 individual</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Quarterly Nursing Review of HCP/Crisis Plans: <ul style="list-style-type: none"> ◦ None found for 5/2008 - 5/2009 (#1) • Special Health Care Needs: <ul style="list-style-type: none"> • Nutritional Plan ◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. • Crisis Plans <ul style="list-style-type: none"> • High Calcium Intake ◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. 	<p>Complete</p>

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</p> <p>PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</p> <p>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff...</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 27 of 35 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"> • First Aid (DSP #52, 55, 57, 59 & 62) • CPR (DSP #42, 45, 59, 69 & 70) • Assisting With Medications (DSP #42, 43, 45, 48, 49, 50, 51, 52, 53, 54, 55, 57, 58, 59, 60, 61, 62, 63, 65, 66, 68, 69, 70, 71, 73 & 74) • Rights & Advocacy (DSP #51) • Level 1 Health (DSP #53) • Teaching & Support Strategies (DSP #53 & 58) • Positive Behavior Supports Strategies (DSP #40 & 54) • Participatory Communication & Choice Making (DSP #53) 	<p>New & Repeat Findings:</p> <p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 3 of 30 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"> • First Aid (DSP #52) • Assisting With Medications (DSP #40 & 60)

Tag # 1A22 Staff Competence	Scope and Severity Rating: D	Scope and Severity Rating: F
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>F. Qualifications for Direct Service Personnel: The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</p> <p>(1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times;</p> <p>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</p> <p>(3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual...</p>	<p>Based on interview, the Agency failed to ensure that training competencies were met for 1 of 14 Direct Service Personnel.</p> <p>When DSP were asked if they had received training regarding the individual's Seizure Disorder the following was reported:</p> <ul style="list-style-type: none"> DSP #56 stated, "I haven't been trained on her seizure plan." According to the ISP, and agency case file the individual has a diagnosis of Seizures. (Individual #8) 	<p>New & Repeat Findings:</p> <p>Based on interview, the Agency failed to ensure that training competencies were met for 1 of 1 Direct Service Personnel.</p> <p>When DSP were asked if the individual had a Positive Behavioral Crisis Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> DSP #40 stated, "I don't think there is one in her book at all." According to the Individual Specific Training Section of the ISP, the individual has Positive Behavioral Crisis Plan. (Individual #8) <p>When DSP were asked if they received training on the Individual's Speech Therapy Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> DSP #40 stated, "I can't honestly say, it's been awhile since she's been here." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #8) <p>When DSP were asked if they received training on the Individual's Occupational Therapy Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> DSP #40 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #8) <p>When DSP were asked if they received training on the Individual's Physical Therapy Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> DSP #40 stated, "I'm not too sure about the Physical Therapy." According to the Individual Specific Training Section of the ISP, the Individual

		<p>requires a Physical Therapy Plan. (Individual #8)</p> <p>When DSP were asked if they received training on the Individual's Health Care Plans and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #40 stated, "Not that I know of." According to Individual Specific Training section of the ISP indicates there are HCPs for Universal Precaution. (Individual #8) <p>When DSP were asked if they assisted the individual with medications and had received the Assisting with Medication Delivery (AWMD) training, the following was reported:</p> <ul style="list-style-type: none"> • DSP #40 stated, "Yes, I believe April 2008." Per DDSD Training Policy, AWMD is an annual re-certification. (Individual #8) <p>When DSP were asked, what are the steps did they need to take before assisting an individual with PRN medication, the following was reported:</p> <ul style="list-style-type: none"> • DSP #40 stated, "No, we don't do that here." As indicated by DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP) (Individual #8)
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Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: E	Scope and Severity Rating: N/A
<p>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</p> <p>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</p> <p>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: A. homicide; B. trafficking, or trafficking in controlled substances; C. kidnapping, false imprisonment, aggravated assault or aggravated battery; D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; E. crimes involving adult abuse, neglect or financial exploitation; F. crimes involving child abuse or neglect; G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p>	<p>Based on record review, the Agency failed to maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 21 of 37 Agency Personnel.</p> <p>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</p> <ul style="list-style-type: none"> • #45 – Date of hire 10/14/1994 • #46 – Date of hire 6/05/2007 • #48 – Date of hire 12/17/2008 • #52 – Date of hire 2/21/2007 • #53 – Date of hire 6/05/2007 • #54 – Date of hire 11/29/2004 • #55 – Date of hire 3/17/1999 • #60 – Date of hire 2/20/2009 • #61 – Date of hire 4/29/2005 • #63 – Date of hire 7/14/1998 • #64 – Date of hire 11/7/2008 • #65 – Date of hire 10/01/2003 • #66 – Date of hire 8/01/2004 • #67 – Date of hire 3/2009 • #68 – Date of hire 11/01/2007 • #69 – Date of hire 6/2/2005 • #70 – Date of hire 10/22/1997 • #71 – Date of hire 9/28/2004 • #72 – Date of hire 11/14/2008 • #73 – Date of hire 11/01/2001 • #74 – Date of hire 2/10/2002 	<p>Complete</p>

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E	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>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 15 of 37 Agency Personnel.</p> <p>The following Agency personnel records contained NO evidence of the Employee Abuse Registry being completed:</p> <ul style="list-style-type: none"> • #40 – Date of hire 4/16/2008 • #43 – Date of hire 1/30/2007 • #44 – Date of hire 4/28/2009 • #47 – Date of hire 6/8/2009 • #48 – Date of hire 12/17/2008 • #49 – Date of hire 2/19/2007 • #52 – Date of hire 2/21/2007 • #53 – Date of hire 6/05/2007 • #56 – Date of hire 12/05/2008 • #60 – Date of hire 2/20/2009 • #64 – Date of hire 11/07/2008 • #67 – Date of hire 3/2009 • #68 – Date of hire 11/01/2007 • #72 – Date of hire 11/14/2008 <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #46 – Date of hire 6/5/2007 	<p>New & 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 32 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #79 – Date of hire 11/4/09. Completed on 5/12/2010.

Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: D	Scope and Severity Rating: N/A
<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:</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 1 of 8 individuals.</p> <p>Individual #2</p> <ul style="list-style-type: none"> • Incident date 9/15/2008. Allegation was Neglect. Incident report was received 9/23/2008. Late Reporting. IMB Late & Failure Report indicated incident was "Confirmed." 	<p>Complete</p>

Tag # 1A28 (CoP) Incident Mgt. System - Policy & Procedure	Scope & Severity Rating: F	Scope and Severity Rating: N/A
<p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>C. Incident Policies: All community based service providers shall maintain policies and procedures, which describe the community based service provider's immediate response to all reported allegations of incidents involving abuse, neglect, or misappropriation of property; all unexpected deaths or natural/expected deaths, and other reportable incidents required as required in Paragraph (2) of Subsection A of 7.1.13.9 NMAC.</p> <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>B. Training Curriculum: The licensed health care facility and community based service provider shall provide all employees and volunteers with a written training curriculum on incident policies and procedures for identification, and timely reporting of abuse, neglect, misappropriation of consumers' property, and where applicable to community based service providers, unexpected deaths or other reportable incidents, within thirty (30) days of the employees' initial employment, and by annual review not to exceed twelve (12) month intervals. The training curriculum may include computer-</p>	<p>Based on record review, the Agency failed to establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement.</p> <p>As indicated by the Mosaic's Incident Management Reporting Orientation and Training; Procedure: 2. "Orientation and Training will be provided within the first 30 days of employment and bi-annually (every two years)" Per NMAC regulation "community based service provider shall provide all employees and volunteers with a written training ... within thirty (30) days of the employees' initial employment, and by annual review not to exceed twelve (12) month intervals."</p>	<p>Complete</p>

based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the licensed health care facilities or community based service provider's facility. Training shall be conducted in a language that is understood by the employee and volunteer.

C. Incident Management System Training Curriculum Requirements:

(1) The licensed health care facility and community based service provider shall conduct training, or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum that includes but is not limited to:

- (a) an overview of the potential risk of abuse, neglect, misappropriation of consumers' property;
- (b) informational procedures for properly filing the division's incident management report form;
- (c) specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and misappropriation of consumers' property.
- (d) specific instructions on how to respond to abuse, neglect, misappropriation of consumers' property;
- (e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, misappropriation of consumers' property; and
- (f) where applicable to employees of community based service providers, informational procedures for properly filing the division's incident management report form for unexpected deaths or other reportable incidents.

Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: E	Scope and Severity Rating: N/A
<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, the Agency failed to provide documentation verifying completion of Incident Management Training for 14 of 37 Agency Personnel.</p> <ul style="list-style-type: none"> • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#47, 51, 55, 60, 63, 65, 66, 67, 69, 70, 71, 72, 74 & 75) 	<p>Complete</p>

Tag # 1A28 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: F	Scope and Severity Rating: N/A
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>E. Consumer and Guardian Orientation Packet: Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.</p>	<p>Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 7 of 8 individuals.</p> <ul style="list-style-type: none"> • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#1, 3, 4, 5, 6, 7 & 8) 	<p>Complete</p>

Tag # 1A28 (CoP) Incident Mgt. System - Posters	Scope & Severity Rating: E	Scope and Severity Rating: N/A
<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 6 of 7 residences:</p> <p>The following locations were identified:</p> <p>Residence of :</p> <ul style="list-style-type: none"> • Individual #1 • Individual #3 • Individual #5 • Individual #6 • Individual #7 • Individual #2 and 8 (Individuals share a home) 	<p>Complete</p>

Tag # 1A29 Complaints / Grievances - Acknowledgement	Scope and Severity Rating: B	Scope and Severity Rating: N/A
<p>NMAC 7.26.3.6 A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC].</p> <p>NMAC 7.26.3.13 Client Complaint Procedure Available. A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p>NMAC 7.26.4.13 Complaint Process: A. (2). The service provider's complaint or grievance procedure shall provide, at a minimum, that: (a) the client is notified of the service provider's complaint or grievance procedure</p>	<p>Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 6 of 8 individuals.</p> <ul style="list-style-type: none"> Grievance/Complaint Procedure Acknowledgement (#1, 2, 3, 5, 7 & 8) 	<p>Complete</p>

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: F	Scope and Severity Rating: N/A
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff...</p>	<p>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 31 of 37 Agency Personnel.</p> <p>Review of personnel records found no evidence of the following:</p> <ul style="list-style-type: none"> Individual Specific Training (#41, 42, 43, 44, 46, 47, 48, 50, 51, 52, 53, 54, 56, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74 & 76) 	<p>Complete</p>

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Scope and Severity Rating: B	Scope and Severity Rating: N/A
<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 2 of 8 individuals receiving Community Inclusion services.</p> <p>Adult Habilitation Quarterly Reports</p> <ul style="list-style-type: none"> • Individual #8 - None found for 3/2009 - 5/2009 <p>Supported Employment Quarterly Reports</p> <ul style="list-style-type: none"> • Individual #4 - None found for 6/2008 - 6/2009 <p>Community Access Quarterly Reports</p> <ul style="list-style-type: none"> • Individual #8 - None found for 3/2009 - 5/2009 	<p>Complete</p>

Tag # 5I11 Reporting Requirements (CI Quarterly Report Components)	Scope and Severity Rating: C	Scope and Severity Rating: N/A
<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: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP.</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 DDS.</p>	<p>Based on record review, the Agency failed to complete written quarterly status reports in compliance with standards for 8 of 8 individuals receiving Community Inclusion Services.</p> <p>Review of quarterly reports found the following components were not addressed, as required:</p> <p>Individual #1, 2, 3, 7 & 8 - The following were not found in the Community Inclusion Quarterly Report for 6/2008 - 6/2009:</p> <p>2) Progress towards desired outcomes in the ISP accomplished during the quarter)</p> <p>10) 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>Individual #1, 2, 3, 4, 5, 6, 7 & 8 - The following were not found in the Community Inclusion Quarterly Report for 6/2008 - 6/2009:</p> <p>3) Significant changes in routine or staffing</p> <p>4) Unusual or significant life events</p> <p>5) Updates on health status, including medication, assistive technology needs and durable medical equipment needs identified during the quarter; and</p> <p>7) Identification and implementation of a meaningful day definition for each person served;</p>	<p>Complete</p>

Tag # 5I22 SE Agency Case File	Scope and Severity Rating: B	Scope and Severity Rating: N/A
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</p> <p>D. Provider Agency Requirements</p> <p>(1) Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDSD. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.</p> <p>(2) The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items:</p> <p>(a) Quarterly progress reports;</p> <p>(b) Vocational assessments (A vocational assessment or profile is an objective analysis of a person's interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDSD;</p> <p>(c) Career development plan as incorporated in the ISP; a career development plan consists of the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks</p>	<p>Based on record review, the Agency failed to maintain a confidential case file for each individual for 2 of 4 individuals receiving Supported Employment Services.</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Required Certificates & Documentation: <ul style="list-style-type: none"> ◦ Certificates of earnings (#5 & 7) 	<p>Complete</p>

including the individual, as well and a review and reporting mechanism for mutual accountability; and

(d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973.

New Mexico Department of Health (DOH)
Developmental Disabilities Supports Division
(DDSD) Policy

Policy Title: Vocational Assessment Profile

Policy Eff July 16, 2008

I. PURPOSE

The intent of the policy is to ensure that individuals are identified who could benefit from Vocational Assessment Profiles (VAPs) and are supported to access this support.

II. POLICY STATEMENT

Individuals served under the Developmental Disabilities Medicaid Waiver (DDW) who express an interest in obtaining employment or exploring employment opportunities, or individuals who desire a VAP and those whose teams identify that they could benefit from a VAP, will have access to a VAP in accordance to the DDW Service Standards and related procedures.

Tag # 5I25 SE Reimbursement	Scope and Severity Rating: C	Scope and Severity Rating: A
<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> <ul style="list-style-type: none"> (i) Researching potential employers via telephone, Internet, or visits; (ii) Writing, printing, mailing, copying, emailing applications, resume, references and corresponding documents; (iii) Arranging appointments for job tours, interviews, and job trials; (iv) Documenting job search and acquisition progress; (v) Contacting employer, supervisor, co-workers and other IDT team members to assess individual's progress, needs and satisfaction; and (vi) Meetings with individual surrounding job development or retention not at the employer's site. <p>(c) Intensive Supported Employment services are</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 4 of 4 individuals</p> <p>Individual #4 June 2009</p> <ul style="list-style-type: none"> • Documentation provided accounted for 18.5 hours of Supported Employment from 6/4/2009 through 6/29/2009. Billing hours were unable to be verified, remittance forms were not provided. <p>Individual #5 May 2009</p> <ul style="list-style-type: none"> • The Agency billed 33.5 hours of Supported Employment from 5/01/2009 through 5/28/2009. Documentation received accounted for 11.5 hours. <p>June 2009</p> <ul style="list-style-type: none"> • Documentation provided accounted for 16 hours of Supported Employment from 6/8/2009 through 6/29/2009. Billing hours were unable to be verified, remittance forms were not provided <p>Individual #6 April 2009</p> <ul style="list-style-type: none"> • The Agency billed 48 hours of Supported Employment from 4/01/2009 through 4/29/2009. Documentation received accounted for 42 hours. <p>May 2009</p> <ul style="list-style-type: none"> • The Agency billed 48.5 hours of Supported Employment from 5/01/2009 through 5/31/2009. Documentation received accounted for 44.5 hours. <p>June 2009</p> <ul style="list-style-type: none"> • Documentation provided accounted for 33 hours of Supported Employment from 6/8/2009 through 6/30/2009. Billing hours were unable to be 	<p>New & Repeat Findings:</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 3 individuals</p> <p>Individual #6 March 2010</p> <ul style="list-style-type: none"> • The Agency billed 64 units of Supported Employment from 3/02/2010 through 3/31/2010. Documentation received accounted for 55.5 units.

<p>intended for individuals who need one-to-one, 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>	<p>verified, remittance forms were not provided</p> <p>Individual #7 May 2009</p> <ul style="list-style-type: none"> • The Agency billed a total of 12 hours of Supported Employment on 5/5/2009 through 5/7/2009. No documentation found to justify billing. 	
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Tag # 5I36 CA Reimbursement	Scope and Severity Rating: C	Scope and Severity Rating: A
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS</p> <p>G. Reimbursement</p> <p>(1) Billable Unit: A billable unit is defined as one-quarter hour of service.</p> <p>(2) Billable Activities: The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions:</p> <p>(a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan;</p> <p>(b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and</p> <p>(c) Non face-to-face hours do not exceed 10% of the monthly billable hours.</p> <p>(3) Non-Billable Activities: Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include:</p> <p>(a) Time and expense for training service personnel;</p> <p>(b) Supervision of agency staff;</p> <p>(c) Service documentation and billing activities; or</p> <p>(d) Time the individual spends in segregated facility-based settings activities.</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 3 of 3 individuals.</p> <p>Individual #1 April 2009</p> <ul style="list-style-type: none"> The Agency billed 312 units of Community Access on 4/01/2009 through 4/24/2009. Documentation received accounted for 24 units. <p>June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 48 units of Community Access from 6/19/2009 through 6/27/2009. Billing units were unable to be verified, remittance forms were not provided. <p>Individual #4 June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 96 units of Community Access from 6/04/2009 through 6/30/2009. Billing units were unable to be verified, remittance forms were not provided. <p>Individual #8 April 2009</p> <ul style="list-style-type: none"> The Agency billed 154 units of Community Access from 4/03/2009 through 4/30/2009. Documentation received accounted for 72 units. <p>May 2009</p> <ul style="list-style-type: none"> The Agency billed 112 units of Community Access from 5/01/2009 through 5/26/2009. Documentation received accounted for 72 units. <p>June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 48 units of Community Access from 6/16/2009 through 6/29/2009. Billing units were unable to be verified, remittance forms were not provided. 	<p>New & Repeat Findings:</p> <p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 1 of 3 individuals.</p> <p>Individual #1 March 2010</p> <ul style="list-style-type: none"> The Agency billed 24 units of Community Access on 3/23/2010. No documentation found to justify billing.

Tag # 5144 AH Reimbursement	Scope and Severity Rating: C	Scope and Severity Rating: B
<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 8 individuals.</p> <p>Individual #1 June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 384 units of Adult Habilitation from 6/01/2009 through 6/30/2009. Billing units were unable to be verified, remittance forms were not provided. <p>Individual #2 April 2009</p> <ul style="list-style-type: none"> The Agency billed 528 units of Adult Habilitation from 4/01/2009 through 4/30/2009. Documentation received accounted for 336 units. <p>June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 504 units of Adult Habilitation from 6/01/2009 through 6/30/2009. Billing units were unable to be verified, remittance forms were not provided. <p>Individual #3 April 2009</p> <ul style="list-style-type: none"> The Agency billed 408 units of Adult Habilitation on 4/01/2009 through 4/30/2009. Documentation received accounted for 216 units. <p>June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 24 units of Adult Habilitation from 6/1/2009 through 6/30/2009. Billing hours were unable to be verified, remittance forms were not provided. <p>Individual #4 June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 432 units of Adult Habilitation from 6/01/2009 through 6/30/2009. Billing units were unable to be 	<p>New & Repeat Findings:</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 5 of 7 individuals.</p> <p>Individual #1 March 2010</p> <ul style="list-style-type: none"> The Agency billed 408 units of Adult Habilitation from 3/01/2010 through 3/31/2010. Documentation received accounted for 384 units. <p>Individual #2 March 2010</p> <ul style="list-style-type: none"> The Agency billed 501 units of Adult Habilitation from 3/01/2010 through 3/31/2010. Documentation received accounted for 456 units. <p>Individual #6 March 2010</p> <ul style="list-style-type: none"> The Agency billed 416 units of Adult Habilitation from 3/01/2010 through 3/31/2010. Documentation received accounted for 376 units. <p>Individual #7 March 2010</p> <ul style="list-style-type: none"> The Agency billed 80 units of Adult Habilitation from 3/01/2010 through 3/31/2010. Documentation received accounted for 64 units. <p>Individual #8 March 2010</p> <ul style="list-style-type: none"> The Agency billed 416 units of Adult Habilitation from 3/01/2010 through 3/31/2010. Documentation received accounted for 368 units.

	<p>verified, remittance forms were not provided.</p> <p>Individual #5 June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 348 units of Adult Habilitation from 6/01/2009 through 6/30/2009. Billing units were unable to be verified, remittance forms were not provided. <p>Individual #6 April 2009</p> <ul style="list-style-type: none"> The Agency billed 392 units of Adult Habilitation from 4/01/2009 through 4/30/2009. Documentation received accounted for 384 units. <p>May 2009</p> <ul style="list-style-type: none"> The Agency billed 360 units of Adult Habilitation from 5/01/2009 through 5/31/2009. Documentation received accounted for 344 units. <p>June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 392 units of Adult Habilitation from 6/01/2009 through 6/30/2009. Billing units were unable to be verified, remittance forms were not provided. <p>Individual #7 April 2009</p> <ul style="list-style-type: none"> The Agency billed 104 units of Adult Habilitation from 4/01/2009 through 4/30/2009. Documentation received accounted for 100 units. <p>June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 4 units of Adult Habilitation from 6/01/2009 through 6/30/2009. Billing units were unable to be verified, remittance forms were not provided. <p>Individual #8 April 2009</p> <ul style="list-style-type: none"> The Agency billed 336 units of Adult Habilitation from 4/01/2009 through 4/30/2009. 	
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	<p>Documentation received accounted for 288 units.</p> <p>May 2009</p> <ul style="list-style-type: none">• The Agency billed 246 units of Adult Habilitation from 5/01/2009 through 5/31/2009. Documentation received accounted for 240 units. <p>June 2009</p> <ul style="list-style-type: none">• Documentation provided accounted for 408 units of Adult Habilitation from 6/01/2009 through 6/30/2009. Billing units were unable to be verified, remittance forms were not provided.	
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Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: E	Scope and Severity Rating: N/A
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS</p> <p>D. Scope of DDSD Agreement</p> <p>(4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite;</p> <p>NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER</p> <p>ELIGIBLE PROVIDERS:</p> <p>I. Qualifications for community living service providers: There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards.</p> <p>(1) Family living service providers for adults must meet the qualifications for staff required by the</p>	<p>Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 3 of 5 individuals.</p> <p>The following was not found, not current and/or incomplete:</p> <ul style="list-style-type: none"> • DDSD Approval for Subcontractor (#5) • Family Living (Annual Update) Home Study (#1, 5 & 6) 	<p>Complete</p>

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

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E	Scope and Severity Rating: N/A
<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>b) That each individual with a score of 4, 5, or 6</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 3 of 8 individuals receiving Community Living Services.</p> <ul style="list-style-type: none"> • Annual Physical (#5) • Dental Exam <ul style="list-style-type: none"> ◦ Individual #5 - As indicated by the documentation reviewed, exam was completed on 5/20/2008. Follow-up was to be completed annually. No evidence of follow-up found. • Vision Exam <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by the documentation reviewed, exam was completed on 7/16/2008. Follow-up was to be completed annually. No evidence of follow-up found. • Bone Density Exam <ul style="list-style-type: none"> ◦ Individual #1 - As indicated by the Agency case file. No evidence of exam was found. 	<p>Complete</p>

<p>on the HAT, has a Health Care Plan developed by a licensed nurse.</p> <p>(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <p>(a) The individual has a primary licensed physician;</p> <p>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</p> <p>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</p> <p>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</p> <p>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</p>		
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Tag # 6L14 Residential Case File	Scope and Severity Rating: F	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</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</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 8 of 8 Individuals receiving Family Living Services or Supported Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ Not Found (#3) ◦ Did not contain Pharmacy Information (#4, 7 & 8) ◦ Did not contain Physician's Information (#4, 7 & 8) • Annual ISP (#5) • Teaching and Support Strategies (#5 & 6) • ISP Signature Page (#3, 4, 6 & 8) • Addendum A (#2, 3, 4 & 8) • Individual Specific Training (Addendum B) (#5) • Speech Therapy Plan (#4, 5 & 8) • Occupational Therapy Plan (#3, 4, 5, 6 & 7) • Physical Therapy Plan (#1, 3 & 5) • Health Assessment Tool (#3, 5 & 7) • Special Health Care Needs <ul style="list-style-type: none"> ◦ Nutritional Plan (#3) • Health Care Plans <ul style="list-style-type: none"> ◦ Constipation (#1) ◦ Seizures (#1 & 4) ◦ Skin Integrity (#1) ◦ At risk for falls (#1) 	<p>Repeat Findings:</p> <p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 2 of 7 Individuals receiving Family Living Services or Supported Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ Did not contain Pharmacy Information (#7) • Occupational Therapy Plan (#6 & 7) • Health Assessment Tool (#7)

<p>a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: <ul style="list-style-type: none"> (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. <p>(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and</p> <p>(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital</p>	<ul style="list-style-type: none"> ◦ Imbalanced Nutrition (#4) ◦ Potential For Trauma (#4) ◦ At risk for Aspiration (#4) <ul style="list-style-type: none"> • Crisis Plan <ul style="list-style-type: none"> ◦ Seizures (#1) ◦ High Calcium Intake (#3) • Progress Notes written by DSP and/or Nurses regarding Health Status: <ul style="list-style-type: none"> ◦ Individual #1 - None found for July - August 2009 ◦ Individual #4 - None found for July - August 2009 • Health Care Providers Written Orders (#5) • Record of visits of healthcare practitioners (#5) 	
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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 (Community Living Quarterly Reports)	Scope and Severity Rating: B	Scope and Severity Rating: N/A
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>D. Community Living Service Provider Agency Reporting Requirements: All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation:</p> <ol style="list-style-type: none"> (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members. 	<p>Based on record review, the Agency failed to complete written quarterly status reports for 3 of 8 individuals receiving Community Living Services.</p> <p>Supported Living Quarterly Reports:</p> <ul style="list-style-type: none"> • Individual #2 - None found for 3/2009 - 5/2009 • Individual #4 - None found for 6/2008 - 6/2009 <p>Family Living Quarterly Reports:</p> <ul style="list-style-type: none"> • Individual #6 - None found for 3/2009 - 5/2009 	<p>Complete</p>

Tag # 6L17 Reporting Requirements (CL Quarterly Report Components)	Scope and Severity Rating: B	Scope and Severity Rating: N/A
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>D. Community Living Service Provider Agency Reporting Requirements: All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation:</p> <ol style="list-style-type: none"> (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members. 	<p>Based on record review, the Agency failed to complete written quarterly status reports in compliance with standards for 5 of 8 individuals receiving Community Living Services.</p> <p>Review of quarterly reports found the following components were not addressed, as required:</p> <p>Individual #2, 3, 4, 5 & 8 - The following were not found in the Community Living Quarterly Report for 6/2008 - 6/2009:</p> <p style="padding-left: 40px;">(3) Significant changes in routine or staffing;</p> <p>Individual #3, 4, 5 & 8 - The following were not found in the Community Living Quarterly Report for 6/2008 - 6/2009:</p> <p style="padding-left: 40px;">(4) Unusual or significant life events;</p> <p style="padding-left: 40px;">(5) Updates on health status, including medication and durable medical equipment needs identified during the quarter.</p>	<p>Complete</p>

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

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

Tag # 6L26 SL Reimbursement	Scope and Severity Rating: C	Scope and Severity Rating: N/A
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES</p> <p>A. Reimbursement for Supported Living Services</p> <p>(1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year.</p> <p>(2) Billable Activities</p> <p>(a) Direct care provided to an individual in the residence any portion of the day.</p> <p>(b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community.</p> <p>(c) Any activities in which direct support staff provides in accordance with the Scope of Services.</p> <p>(3) Non-Billable Activities</p> <p>(a) The Supported Living Services provider shall not bill DD Waiver for Room and Board.</p> <p>(b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services.</p> <p>(c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 3 of 3 individuals.</p> <p>Individual #2 June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 30 units of Supported Living from 6/01/2009 through 6/30/2009. Billing units were unable to be verified, remittance forms were not provided. <p>Individual #4 June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 30 units of Supported Living from 6/01/2009 through 6/30/2009. Billing units were unable to be verified, remittance forms were not provided. <p>Individual #8 June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 30 units of Supported Living from 6/01/2009 through 6/30/2009. Billing units were unable to be verified, remittance forms were not provided. 	<p>Complete</p>

Tag # 6L27 FL Reimbursement	Scope and Severity Rating: B	Scope and Severity Rating: N/A
<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> <p>(a) Direct support provided to an individual in the residence any portion of the day;</p> <p>(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</p> <p>(c) Any other activities provided in accordance with the Scope of Services.</p> <p>(3) Non-Billable Activities shall include:</p> <p>(a) The Family Living Services Provider Agency may not bill the for room and board;</p> <p>(b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and</p> <p>(c) Family Living services may not be billed for the same time period as Respite.</p> <p>(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>	<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 4 of 5 individuals.</p> <p>Individual #1 June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 28 units of Supported Living from 6/01/2009 through 6/30/2009. Billing units were unable to be verified, remittance forms were not provided. <p>Individual #3 June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 30 units of Family Living from 6/01/2009 through 6/30/2009. Billing units were unable to be verified, remittance forms were not provided. <p>Individual #5 April 2009</p> <ul style="list-style-type: none"> The Agency billed 30 units of Family Living from 4/01/2009 through 4/30/2009. Documentation received accounted for 26 units. <p>June 2009</p> <ul style="list-style-type: none"> Documentation provided accounted for 30 units of Family Living from 6/01/2009 through 6/30/2009. Billing units were unable to be verified, remittance forms were not provided. <p>Individual #6 April 2009</p> <ul style="list-style-type: none"> The Agency billed 28 units of Family Living from 4/01/2009 through 4/30/2009. Documentation received accounted for 24 units. <p>May 2009</p> <ul style="list-style-type: none"> The Agency billed 28 units of Family Living from 5/01/2009 through 5/30/2009. Documentation received accounted for 25 units. 	<p>Complete</p>

June 2009

- Documentation provided accounted for 26 units of Family Living from 6/01/2009 through 6/30/2009. Billing units were unable to be verified, remittance forms were not provided.