



Alfredo Vigil, MD
Secretary

DEPARTMENT OF

Building a Healthy New Mexico!

Bill Richardson, Governor

Katrina Hotrum
Deputy Secretary

Jessica Sutin
Deputy Secretary

Michael Mulligan
Acting Deputy Secretary

Karen Armitage, MD
Chief Medical Officer

Date: July 1, 2010

To: Larry Alflen, Executive Director
Provider: Zuni Entrepreneurial Enterprises, Inc.
Address: P.O. Drawer 989
State/Zip: Zuni, New Mexico 87327

E-mail Address: zeelea@nm.net

CC: Ms. Dorothea Lahi, Board Chair
Address: P.O. Drawer 989
State/Zip: Zuni, NM 87327

Region: Northwest
Survey Date: June 21 - 23, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living) & Community Inclusion (Adult Habilitation)
Survey Type: Focused
Team Leader: Cynthia Nielsen MSN RN ONC CCM, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Florie Alire RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Wendy Kramer RN, Healthcare Surveyor, Developmental Disabilities Support Division & Tamara Peterson RN, Healthcare Surveyor, Developmental Disabilities Support Division.

Dear Mr. Alflen,

The Division of Health Improvement Quality Management Bureau has completed a focused survey of the service identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. The specific focus of the survey was to determine compliance with Nursing/Health Care oversight related to concerns identified as a result of the April 2010 Jackson Community Practice Review.

Plan of Correction:

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

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



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

David Rodriguez, Division Director • Division of Health Improvement

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

DHI Quality Review Survey Report – ZEE, Inc. - Northwest Region – June 21 - 23, 2010

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

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

Request for Informal Reconsideration of Findings (IRF):

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

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

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

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

Please call the Team Leader at 505-795-1057, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Cynthia Nielsen, RN

Cynthia Nielsen RN
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date: June 21, 2010

Present:

ZEE, Inc.

Sarah Huber, Associate Director
Timothy Terrell, Transportation Supervisor
Heather Iule, Administrative Services
Bernadine Leekela, Residential Services

DOH/DHI/QMB

Cynthia Nielsen RN/Team Lead/Healthcare Surveyor
Florie Alire RN/Healthcare Surveyor

DDSD

Wendy Kramer RN - Metro Regional Office
Tamara Peterson RN - Northwest Regional Office

Exit Conference Date: June 23, 2010

Present:

ZEE, Inc.

Larry Alfien, Executive Director
Sarah Huber, Associate Director
Timothy Terrell, Transportation Supervisor
Heather Iule, Administrative Services
Bernadine Leekela, Residential Services
Todd Naktewa, Day Hab Services

DOH/DHI/QMB

Cynthia Nielsen RN, Team Lead/Healthcare Surveyor
Florie Alire RN, Healthcare Surveyor

DDSD

Tamara Peterson RN, Northwest Regional Office
Crystal Wright, Northwest Regional Office Director (via phone)
Wendy Kramer RN, Metro Regional Office (via phone)

Homes Visited Number: 4

Administrative Locations Visited Number: 1

Total Sample Size Number: 8
1 - Jackson Class Members
7 - Non-Jackson Class Members
5 - Supported Living
8 - Adult Habilitation

Persons Served Interviewed Number: 7

Persons Served Observed Number: 1 (One Individual was not in attendance during on-site visit)

Records Reviewed (Persons Served) Number: 8

Administrative Files Reviewed

- Medical Records
- Agency Policy and Procedure (On-call including nursing, medication assistance and delivery, medication errors and storage of medication)
- Nursing personnel files

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

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

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

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

Key to Scope scale:

Isolated:

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

Pattern:

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

Widespread:

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

Key to Findings:

“Substantial Compliance with Conditions of Participation”

The QMB determination of “Substantial Compliance with Conditions of Participation” indicates that a provider is in substantial compliance with all ‘Conditions of Participation’ and other standards and regulations. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals’ health and safety. To qualify for a determination of Substantial Compliance with Conditions of Participation, the provider must not have any findings that meet the thresholds for determining non-compliance with any Condition of Participation.

“Non-Compliance with Conditions of Participation”

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

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

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

Introduction:

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

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

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

The following limitations apply to the IRF process:

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

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

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

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

Agency: Zuni Entrepreneurial Enterprises, Inc. - Northwest Region
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living) & Community Inclusion (Adult Habilitation)
Monitoring Type: Focused Survey
Date of Survey: June 21 - 23, 2010

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A08 Agency Case File	Scope and Severity Rating: B		
<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 and telephone number, and health plan if appropriate;</p> <p>(2) The individual's complete and current ISP, with</p>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 4 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"> • Physical Therapy Plan (#6) • Progress Notes written by DSP or Nurses regarding Health Status, Physical Condition and Actions Taken: <ul style="list-style-type: none"> ◦ None found for 5/2009 - 5/2010 (#2 & 4) • Annual Physical (#3) • Dental Exam <ul style="list-style-type: none"> ◦ Individual #2 - As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #3 – As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #4 – As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of exam was found. 		

<p>all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);</p> <p>(3) Progress notes and other service delivery documentation;</p> <p>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</p> <p>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p>	<ul style="list-style-type: none"> • Vision Exam <ul style="list-style-type: none"> ◦ Individual #3 - As indicated by the DDS file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #4 – As indicated by the DDS file matrix, Vision Exams are to be conducted every other year. No evidence of the exam was found. • Auditory Exam <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by the documentation reviewed, exam was completed on 12/17/2008. Follow-up was to be completed in 12/09. No evidence of follow-up found. • Primary Care Provider Follow-up <ul style="list-style-type: none"> ◦ Individual #3- As indicated by the Annual Physical Exam done 5/6/09, the Individual was to return to the PCP 8/09 to follow-up on elevated blood glucose. No evidence of the visit was found. ◦ Individual #4 – As indicated by the hospitalization discharge paperwork, the Individual-was to see the PCP on 6/11/10. No evidence of the visit was found. 		
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Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: F		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <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 	<p>Medication Administration Records (MAR) were reviewed for the months of February, March & April 2010.</p> <p>Based on record review, 5 of 5 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #1 April 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> Oyst Cal D (2 times daily) – Blank 4/17 & 25 (9AM) <p>Individual #5 February 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> Prilosec OTC 20mg (1 time daily) – Blank 2/16 (8PM) Colace 100mg (2 times daily) – Blank 2/16 (8PM) Reglan 5mg (3 times daily) – Blank 2/4, 8 & 15 (12PM) & 2/4, 16, 24 & 25 (8PM) Renevela 800mg (3 times daily) – Blank 2/12 (8AM); 2/8, 14 & 22 (12PM) & 2/4, 16, 24, 25 & 28 (8PM). <p>March 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> Lantus 16 units (1 time daily) – Blank 3/14 & 21 		

<p>adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued 	<p>(8PM)</p> <ul style="list-style-type: none"> • Prilosec OTC 20mg (1 time daily) – Blank 3/30 & 31 (8PM) • Amitriptyline 25mg (1 time daily) – Blank 3/31 (8PM) • Bupropion 100mg (2 times daily) – Blank 3/31 (5PM) • Reglan 5mg (3 times daily) – Blank 3/14 & 21 (8AM); 3/14, 21, 28 & 29 (12PM) & 3/9 & 28 (8PM) • Renevela 800mg (3 times daily) – Blank 3/14 & 21 (8AM); 3/8, 14, 21, 28 & 29 (12PM) and 3/1, 9 & 28 (8PM) <p>April 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Reglan 5mg (3 times daily) – Blank 3/29 (12PM) & 3/30 (8PM) <p>Individual #6 February 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Oxybutinin 5mg (2 times daily) – Blank 2/26 (7AM) <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"> • Oxybutinin 5mg (2 times daily) 		
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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. 	<ul style="list-style-type: none"> • Multivit (1 time daily) • Piroxicam 20mg (1 time daily) <p>Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records:</p> <ul style="list-style-type: none"> • Phenobarbital 32.4mg (2 times daily) <p>March 2010</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"> • Oxybutinin 5mg (2 times daily) • Multivit (1 time daily) • Piroxicam 20mg (1 time daily) <p>Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records:</p> <ul style="list-style-type: none"> • Phenobarbital 32.4mg (2 times daily) <p>April 2010</p> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Ibuprofen 400mg (4 times daily) – Blank 4/16 & 4/17 (2PM) <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"> • Oxybutinin 5mg (2 times daily) 		
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	<ul style="list-style-type: none"> • Multivitamin (1 time daily) • Clotimazole 1% cream (2 times daily) • Ibuprofen 400mg (4 times daily) <p>Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records:</p> <ul style="list-style-type: none"> • Phenobarbital 32.4mg (2 times daily) <p>Individual #7 February 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Aricept 10mg (1 time daily) – Blank 2/8 & 14 (10PM) • Prenatal Plus (1 time daily) – Blank 2/5, 7, 14, 21 & 26 (8AM) • Paxil 40mg (1 time daily) – Blank 2/5, 7, 13, 14, 21 & 26 (8AM) • Zocor 20mg (1 time daily) – Blank 2/8 (8AM) <p>March 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Simvastatin 20mg (1 time daily) – Blank 2/19 (8PM) • Aricept 10mg (1 time daily) – Blank 2/19 (10PM) <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p>		
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	<ul style="list-style-type: none"> • Simvastatin 20mg (1 time daily) <p>Individual #8 February 2010 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"> • Calcium w/vitamin D 600mg (2 times daily) <p>March 2010 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"> • Calcium w/vitamin D 600mg (2 times daily) <p>April 2010 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"> • Calcium w/vitamin D 600mg (2 times daily) 		
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Tag # 1A09 Medication Delivery - PRN Medication	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <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 	<p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 2 of 5 Individuals.</p> <p>Individual #5 March 2010</p> <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> Guaifenesin DM 100mg/10ml – PRN – 3/27 (given 1 time) & 3/28 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> Guaifenesin DM 100mg/10ml – PRN – 3/27 (given 1 time) & 3/28 (given 1 time) <p>April 2010</p> <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> Tylenol 325mg – PRN –4/28 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> Tylenol 325mg – PRN –4/28 (given 1 time) <p>Individual #6 April 2010</p> <p>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> Acetaminophen – PRN – 4/5 (given 1 time) & 4/9 (given 1 time). <p>No Effectiveness was noted on the Medication</p>		

<p>adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; 	<p>Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Acetaminophen – PRN – 4/5 (given 1 time) & 4/9 (given 1 time) 		
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- (viii) Time taken and staff initials;
- (ix) Dates when the medication is discontinued or changed;
- (x) The name and initials of all staff administering medications.

Model Custodial Procedure Manual

D. Administration of Drugs

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

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

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

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F. PRN Medication

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

where the provider is related by affinity or by consanguinity to the individual.

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

H. Agency Nurse Monitoring

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

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C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of

consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).

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

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

Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</p> <p>(a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training:</p> <ul style="list-style-type: none"> (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. <p>(b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 3 of 8 individual</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Health Assessment Tool (#3 & 4) • Medication Administration Assessment Tool (#3) • Special Health Care Needs: <ul style="list-style-type: none"> • Nutritional Evaluation <ul style="list-style-type: none"> ◦ Individual #5 – As indicated by the IST section of the ISP, the individual is required to have an evaluation. No evidence of evaluation found. • Crisis Plans <ul style="list-style-type: none"> • Aspiration Crisis Plan <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by a recent hospitalization for aspiration pneumonia, the individual is required to have a plan. • Seizure Crisis Plan <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan. • GERD Crisis Plan <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan. 		

<p>agency nurse must be available to assist the caregiver upon request.</p> <p>(c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first.</p> <p>(d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDS Medication Assessment and Delivery Policy).</p> <p>(e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as <i>subjective</i> information including the individual complaints, signs and symptoms noted by staff, family members or other team members; <i>objective</i> information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); <i>assessment</i> of the clinical status, and <i>plan</i> of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.</p> <p>(2) Health related plans</p> <p>(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or</p>			
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<p>other appropriately designated healthcare professional.</p> <p>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.</p> <p>(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.</p> <p>(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.</p> <p>(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):</p> <p>(a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.</p> <p>(b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.</p> <p>(c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other</p>			
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interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan.

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

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

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

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

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

(4) General Nursing Documentation

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

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

Tag # 1A22 Staff Competence	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>F. Qualifications for Direct Service Personnel: The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</p> <ol style="list-style-type: none"> (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the 	<p>Based on interview, the Agency failed to ensure that training competencies were met for 2 of 10 Direct Service Personnel.</p> <p>When DSP were asked if they received training on the Individual's ISP and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #49 stated, "I have had training on the ISP." When surveyors asked for the DSP to describe what they know about the Individual from the ISP the DSP was not able to. (Individual #4) <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 #45 stated, "Administer the med and then put in on the MAR-front and back." When DSP was asked if they needed to call the nurse prior to assisting the Individual, DSP #45 stated, "No, not unless there is an adverse reaction." According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. (Individual #1) 		

<p>qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and</p> <p>(5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support.</p> <p>(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:</p> <p>(a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services;</p> <p>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</p> <p>(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p>			
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Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</p> <p>G. Health Care Requirements for Community Living Services.</p> <p>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first.</p> <p>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <p>(a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p>	<p>Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 3 of 5 individuals receiving Community Living Services.</p> <ul style="list-style-type: none"> • Dental Exam <ul style="list-style-type: none"> ◦ Individual #5 - As indicated by the documentation reviewed, the exam was completed on 7/30/2008. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found. ◦ Individual #8 - As indicated the documentation reviewed, the exam was completed on 10/30/00. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found. • Vision Exam/Eye Exam <ul style="list-style-type: none"> ◦ Individual #6 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found. 		

<p>b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.</p> <p>(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <ul style="list-style-type: none"> (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine). 			
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Tag # 6L14 Residential Case File	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>A. Residence Case File: For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:</p> <p>(1) Complete and current ISP and all supplemental plans specific to the individual;</p> <p>(2) Complete and current Health Assessment Tool;</p> <p>(3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;</p> <p>(4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);</p> <p>(5) Data collected to document ISP Action Plan implementation</p> <p>(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 4 of 5 Individuals receiving Supported Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Occupational Therapy Plan (#1) • Physical Therapy Plan (#6 & 8) • Special Health Care Needs <ul style="list-style-type: none"> ◦ Nutritional Plan (#5) • Crisis Plan <ul style="list-style-type: none"> ◦ Seizures (#6 & 8) 		

<p>(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: <ul style="list-style-type: none"> (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. <p>(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and</p> <p>(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food,</p>			
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environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.

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

