

Date: January 5, 2011  
To: Susan Karcz, Executive Director  
Provider: A Better Way of Living  
Address: 117 Montclair, SE  
State/Zip: Albuquerque, New Mexico 87108

E-mail Address: [susan@ABetterWayNM.org](mailto:susan@ABetterWayNM.org)

Region: Metro  
Survey Date: Month November 1 - 4, 2010  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Community Living (Supported Living) & Community Inclusion (Adult Habilitation & Supported Employment)  
Survey Type: Routine  
Team Leader: Stephanie R. Martinez de Berenger, M.P.A., GCDF, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Team Members: Florie Alire, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Lori Drury, BA, Developmental Disabilities Supports Division

Dear Ms. Karcz:

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider contracts. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

**Quality Management Compliance Determination:**

The Division of Health Improvement is issuing your agency a determination of "Non-Compliance with Conditions of Participation."

**Plan of Correction:**

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

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

Upon notification from QMB that your Plan of Correction has been approved, you must implement all remedies and corrective actions within 45 working days. If your Plan of Correction is denied, you must resubmit a revised plan as



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

**Roger Gillespie, Acting 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>

QMB Report of Findings – A Better Way of Living – Metro Region – November 1 – 4, 2010

soon as possible for approval, as all remedies must still be completed within 45 working days of the receipt of this letter.

Failure to submit, complete or implement your Plan of Correction within the 45 day required time frames may 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 finding of deficient practice, 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

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The 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 or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator at 505-222-8647 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

*Stephanie R. Martinez de Berenger, MPA, GCDF*  
Stephanie R. Martinez de Berenger, M.P.A., GCDF  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date: November 1, 2010

Present: **A Better Way of Living**  
Susan Karcz - Salazar, Executive Director

**DOH/DHI/QMB**  
Stephanie R. Martinez de Berenger, M.P.A., GCDF,  
Team Lead/Healthcare Surveyor  
Florie Alire, RN, Healthcare Surveyor

**DDSD - Metro Regional Office**  
Lori Drury, Community Inclusion Coordinator

Exit Conference Date: November 4, 2010

Present: **A Better Way of Living**  
Susan Karcz – Salazar, Executive Director  
Michael Hochron, Program Support Specialist/Incident Management  
Coordinator  
Sabrina Smith, Administrative Director  
Theresa Priest, Quality Assurance Director  
Christopher Johnson, Residential Program Director/Service  
Coordinator/Incident Management Coordinator  
Tam Reyes, Residential Supervisor  
John Noel, Supported Employment Director

**DOH/DHI/QMB**  
Stephanie R. Martinez de Berenger, M.P.A., GCDF,  
Team Lead/Healthcare Surveyor  
Cynthia Nielsen, RN, MSN, Healthcare Surveyor  
Florie Alire, RN, Healthcare Surveyor

**DDSD - Metro Regional Office**  
Lori Drury, Community Inclusion Coordinator

Total Homes Visited	Number:	4
❖ Supported Homes Visited	Number:	4
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	9 2 - Jackson Class Members 7 - Non-Jackson Class Members 5 - Supported Living 6 - Adult Habilitation 6 - Supported Employment
Persons Served Interviewed	Number:	9
Direct Service Personnel Interviewed	Number:	7
Records Reviewed (Persons Served)	Number:	9
Administrative Files Reviewed		<ul style="list-style-type: none"><li>• Billing Records</li><li>• Medical Records</li><li>• Incident Management Records</li><li>• Personnel Files</li></ul>

- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Human Rights Notes and/or Meeting Minutes
- Evacuation Drills
- Quality Assurance / Improvement Plan

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

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

### **Introduction:**

After a QMB Compliance Review, your QMB Report of Findings will be sent to you via US mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued non compliance.

Agencies must submit their Plan of Correction within 10 business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 days will be referred to the Internal Review Committee [IRC] for sanctions).

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-222-8647 or email at [George.Perrault@state.nm.us](mailto:George.Perrault@state.nm.us). Requests for technical assistance must be requested through your DDS Regional Office.

If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) working days of receiving your report. The POC process cannot resolve disputes regarding findings. Please note that you must still submit a POC for findings that are in question (see Attachment "C").

### **Instructions for Completing Agency POC:**

#### **Required Content**

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan. (see page 3, DDW standards, effective; April 1, 2007, Chapter 1, Section I Continuous Quality Management System)

If a deficiency has already been corrected, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

The Plan of Correction you submit needs to address **each deficiency** in the two right hand columns with:

1. How the corrective action will be accomplished for all cited deficiencies in the report of findings;
2. How your Agency will identify all other individuals having the potential to be affected by the same deficient practice;
3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur and corrective action is sustained;
4. How your Agency plans to monitor corrective actions utilizing its continuous Quality Assurance/Quality Improvement Plan to assure solutions in the plan of correction are achieved and sustained, including (if appropriate):
  - Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
  - Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
  - Your processes for ensuring that all staff are trained in Core Competencies, Incident Reporting, and Individual-Specific service requirements, etc;
  - How accuracy in Billing documentation is assured;

- How health, safety is assured;
  - For Case Management Providers, how ISPs are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
  - Your process for gathering, analyzing and responding to Quality data, and
  - Details about Quality Targets in various areas, current status, Analyses about why Targets were not met, and remedies implemented.
5. The individual's title responsible for the Plan of Correction and completion date.

**Note: Instruction or in-service of staff alone may not be a sufficient plan of correction.** This is a good first step toward correction, but additional steps should be taken to ensure the deficiency is corrected and will not recur.

### **Completion Dates**

The plan of correction must include a **completion date** (entered in the far right-hand column). Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 days.

Direct care issues should be corrected immediately and monitored appropriately. Some deficiencies may require a staged plan to accomplish total correction. Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

### **Plan of Correction Submission Requirements**

1. Your Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. If you have questions about the POC process, call the POC Coordinator, George Perrault at 505-222-8647 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to George Perrault, POC Coordinator in any of the following ways:
  - a. Electronically at [George.Perrault@state.nm.us](mailto:George.Perrault@state.nm.us)
  - b. Faxed to 505-222-8661, or
  - c. Mailed to QMB, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not send supporting documentation to QMB until after your POC has been approved by QMB.
6. QMB will notify you when your POC has been "approve" or "denied."
  - a. Whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
  - b. If your POC is "Denied" it must be revised and resubmitted as soon as possible, as the 45 working day limit is in effect.
  - c. If your POC is "Denied" a second time your agency may be referred to the Internal Review Committee.
  - d. You will receive written confirmation that your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.
8. Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

### ***POC Document Submission Requirements***

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.
2. You may submit your documents by postal mail, fax, or electronically on disc or scanned and attached to e-mails.
3. All submitted documents must be annotated: please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. For billing deficiencies, you must submit:
  - a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
  - b. Copies of “void and adjust” forms submitted to correct all over-billed or unjustified units billed identified during your internal audit.

## QMB Scope and Severity Matrix

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 Compliance Determination.

		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:

- **Isolated:**  
A deficiency that is limited to 1% to 15% of the sample, usually impacting few 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 could be referred to the Internal Review Committee for review and possible actions or sanctions.

## QMB Determinations of Compliance

- “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 be in compliance with all Conditions of Participation.

- “Non-Compliance with Conditions of Participation”

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

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

- “Sub-Standard Compliance with Conditions of Participation”:

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

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

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

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

### **Introduction:**

Throughout the QMB Survey 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. Providers may use the following process to informally dispute a finding.

### **Instructions:**

1. The Informal Reconsideration of the Finding (IRF) request must be in writing to the QMB Deputy Bureau Chief **within 10 working days** of receipt of the final report.
2. 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>
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.

### **The following limitations apply to the IRF process:**

- The request for an IRF and all supporting evidence must be received within 10 working 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 or requested 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 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 compliance determination or the length of their DDS provider contract.

A Provider forfeits the right to an IRF if the request is not made within 10 working days of receiving the report and/or 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 removed or modified, it will be noted and removed or modified from the Report of Findings. 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:** A Better Way of Living – Metro Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Living (Supported Living) & Community Inclusion (Adult Habilitation & Supported Employment)  
**Monitoring Type:** Routine Survey  
**Date of Survey:** November 1 – 4, 2010

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<b>Tag # 1A08 Agency Case File</b>	<b>Scope and Severity Rating: A</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>D. Provider Agency Case File for the Individual:</b> 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 all supplemental plans specific to the individual,</p>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 1 of 9 individuals.</p> <p>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> <li>• Annual Physical (#7)</li> </ul>		

<p>and the most current completed Health Assessment Tool (HAT);</p> <p>(3) Progress notes and other service delivery documentation;</p> <p>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</p> <p>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p>			
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Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: F	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>E. Medication Delivery:</b> Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <ol style="list-style-type: none"> <li>The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;</li> <li>Prescribed dosage, frequency and method/route of administration, times and dates of administration;</li> <li>Initials of the individual administering or assisting with the medication;</li> <li>Explanation of any medication irregularity;</li> <li>Documentation of any allergic reaction or adverse medication effect; and</li> </ol>	<p>Medication Administration Records (MAR) were reviewed for the months of July, August &amp; September 2010.</p> <p>Based on record review, 6 of 6 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #1 July, August and September 2010 As indicated by the Medication Administration Records the individual is to take Ferrous Sulfate 325mg (3 times daily). According to the Physician's Orders, Ferrous Sulfate 325 mg was discontinued June 10, 2010. Medication Administration Record &amp; Physician's Orders do not match.</p> <p>Individual #2 July and August 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>Ibuprofen 100 mg (1 time daily)</li> <li>Tylenol 80 mg (2 times daily)</li> <li>Maalox 4occ with Benadryl 20cc with viscous Lidocaine 10cc (2 times daily)</li> <li>Zyrtec 10 mg (1 time daily)</li> </ul> <p>Individual #3 July, August and September 2010 As indicated by the Medication Administration Records the individual is to take Lexapro 20mg (1 time daily) and Lexapro 10 mg (1 time daily). According to the Physician's Orders, Lexapro 20 mg (1 + ½ P.O time daily) was ordered March 29, 2010. Medication Administration Record &amp; Physician's Orders do not match.</p>	

<p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p><b>NMAC 16.19.11.8 MINIMUM STANDARDS:</b>  <b>A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</b></p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, <b>including over-the-counter medications</b>. This documentation shall include:</p> <ul style="list-style-type: none"> <li>(i) Name of resident;</li> <li>(ii) Date given;</li> <li>(iii) Drug product name;</li> <li>(iv) Dosage and form;</li> <li>(v) Strength of drug;</li> <li>(vi) Route of administration;</li> <li>(vii) How often medication is to be taken;</li> <li>(viii) Time taken and staff initials;</li> <li>(ix) Dates when the medication is discontinued or changed;</li> <li>(x) The name and initials of all staff</li> </ul>	<p>Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> <li>• Trifluoperazine 1 mg (2 times daily)</li> </ul> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Macrobid 1 (1 time daily) – Blank 9/13, 14, 15, 16 &amp; 17</li> <li>• Bactrim DS 800 mg (2 times daily) – Blank 9/1, 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 &amp; 30 (8:00 AM &amp; PM)</li> </ul> <p>Individual #4  July 2010  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Check Blood Sugar Levels (2 times daily) – Blank 7/1, 2, 3, 6, 9, 17, 20, 22, 27 &amp; 31 (6:00 PM)</li> <li>• Hold Clonidine (2 times daily) – Blank 7/1 (8:00 AM)</li> <li>• Hold Clonidine (2 times daily) – Blank 7/1, 2, 3, 6, 9, 17, 20, 22, 27 &amp; 31 (8:00 PM)</li> </ul> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Clonidine 0.2 mg (2 times daily)</li> </ul> <p>August 2010  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Check Blood Sugar Levels (2 times daily) –</li> </ul>		
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<p>administering medications.</p> <p><b>Model Custodial Procedure Manual</b>  <b>D. Administration of Drugs</b>  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"> <li>➤ symptoms that indicate the use of the medication,</li> <li>➤ exact dosage to be used, and</li> <li>➤ the exact amount to be used in a 24 hour period.</li> </ul>	<p>Blank 8/2 (8:00 AM)</p> <ul style="list-style-type: none"> <li>• Hold Clonidine (2 times daily) – Blank 8/2 (8:00 AM)</li> <li>• Hold Clonidine (2 times daily) – Blank 8/28 (6:00 PM)</li> </ul> <p>Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> <li>• Hold Clonidine (2 times daily)</li> <li>• Clonidine 0.2 mg (2 times daily)</li> <li>• Risperidone 3 mg (1 time daily)</li> <li>• Trazodone 100 mg (1 time daily)</li> </ul> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Trazodone 100 mg (1 times daily) – Blank 8/9 &amp; 30</li> </ul> <p>September 2010</p> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Check Blood Sugar Levels (2 times daily) – Blank 09/26 (8:00 AM)</li> <li>• Hold Clonidine (2 times daily) – Blank 09/26 (8:00 AM)</li> </ul> <p>Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> <li>• Hold Clonidine (2 times daily)</li> <li>• Clonidine 0.2 mg (2 times daily)</li> </ul>		
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	<ul style="list-style-type: none"> <li>• Risperidone 2 mg (1 time daily)</li> <li>• Trazodone 100 mg (1 time daily)</li> </ul> <p>Individual #5 July and August 2010 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> <li>• Clonazepam 0.25 mg (1 times daily)</li> </ul> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Clonidine 0.2 mg (2 times daily)</li> </ul> <p>Individual #6 July 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Cephalexin 500 mg (4 times daily) – Blank 7/24 &amp; 25 (12:00 PM)</li> </ul> <p>August 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Thorazine 50 mg (1 time daily) – Blank 8/9 &amp; 30 (12:00 PM)</li> </ul> <p>September 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Thorazine 50 mg (1 time daily) – Blank 9/7 &amp; 9 (12:00 PM)</li> </ul>		
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Tag # 1A09.1 Medication Delivery - PRN Medication	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>E. Medication Delivery:</b> Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <ol style="list-style-type: none"> <li>The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;</li> <li>Prescribed dosage, frequency and method/route of administration, times and dates of administration;</li> <li>Initials of the individual administering or assisting with the medication;</li> <li>Explanation of any medication irregularity;</li> <li>Documentation of any allergic reaction or adverse medication effect; and</li> </ol>	<p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 2 of 6 Individuals.</p> <p>Individual #2 July, August and September 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> <li>Zyrtec 5 mg (PRN)</li> <li>Promethazine 12.5 mg tabs (PRN)</li> </ul> <p>Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> <li>Tylenol 500 mg (PRN)</li> </ul> <p>Individual #4 July, August and September 2010 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> <li>Glucagon Injection 1 mg (PRN)</li> <li>Diphenhydram 50 mg caps (PRN)</li> </ul>		

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

**Model Custodial Procedure Manual**

***D. Administration of Drugs***

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

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

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

**Department of Health**

**Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006**

**F. PRN Medication**

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

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

**H. Agency Nurse Monitoring**

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

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

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

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

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

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

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p><b>C. Orientation and Training Requirements:</b> Orientation and training for direct support staff and his or her supervisors shall comply with the DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <ol style="list-style-type: none"> <li>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</li> <li>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</li> </ol> <p><b>Department of Health (DOH)</b>  <b>Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 3 of 59 Direct Service Professionals.</p> <p>Review of Direct Service Professional training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> <li>• First Aid (DSP #41 &amp; 51)</li> <li>• CPR (DSP #41 &amp; 51)</li> <li>• Teaching &amp; Support Strategies (DSP #84)</li> <li>• Participatory Communication and Choice Making (PCCM) (DSP #41)</li> </ul>		

accordance with the specifications described in the individual service plan (ISP) of each individual served.

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

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

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

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

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

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

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

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E		
<p><b>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:</b> Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. <b>Provider requirement to inquire of registry.</b> A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. <b>Prohibited employment.</b> A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>D. <b>Documentation of inquiry to registry.</b> The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p> <p>E. <b>Documentation for other staff.</b> With</p>	<p>Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 12 of 61 Agency Personnel.</p> <p><b>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</b></p> <ul style="list-style-type: none"> <li>• #42 – Date of hire 08/01/2006. Completed 01/22/2007.</li> <li>• #45 – Date of hire 09/13/2006. Completed 10/24/2006.</li> <li>• #55 – Date of hire 11/26/2007. Completed 11/29/2007.</li> <li>• #57 – Date of hire 08/02/2007. Completed 08/29/2007.</li> <li>• #62 – Date of hire 02/02/2008. Completed 02/26/2008.</li> <li>• #76 – Date of hire 07/31/2007. Completed 08/29/2007.</li> <li>• #77 - Date of hire 09/13/2006. Completed 10/24/2006.</li> <li>• #78 – Date of hire 03/29/2006. Completed 04/12/2006.</li> <li>• #80 – Date of hire 07/10/2007. Completed 08/29/2007.</li> <li>• #90 – Date of hire 01/23/2006. Completed 11/04/2010.</li> </ul>		

respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.

F. **Consequences of noncompliance.** The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007

**Chapter 1.IV. General Provider Requirements.**

**D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

- #91 - Date of hire 07/07/2007. Completed 08/29/2007.
- #93 – Date of hire 09/08/2009. Completed 09/10/2009.

Tag # 1A33.1 Board of Pharmacy - Lic	Scope and Severity Rating: A		
<p><b>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual</b></p> <p><b>6. Display of License and Inspection Reports</b></p> <p>A. The following are required to be publicly displayed:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Current Custodial Drug Permit from the NM Board of Pharmacy</li> <li><input type="checkbox"/> Current registration from the consultant pharmacist</li> <li><input type="checkbox"/> Current NM Board of Pharmacy Inspection Report</li> </ul>	<p>Based on observation, the Agency failed to provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 1 of 4 residences:</p> <p>Individual Residence:</p> <ul style="list-style-type: none"> <li>• Current Registration of Consulting Pharmacist (#3)</li> </ul>		

Tag # 5I25 SE Reimbursement	Scope and Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>A. General:</b> 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>B. Billable Units:</b> 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"> <li>(1) Date, start and end time of each service encounter or other billable service interval;</li> <li>(2) A description of what occurred during the encounter or service interval; and</li> <li>(3) The signature or authenticated name of staff providing the service.</li> </ol> <p><b>MAD-MR: 03-59 Eff 1/1/2004</b></p> <p><b>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b></p> <p>Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</b></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 6 individuals</p> <p>Individual #8 September 2010</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 9/1/2010 through 9/30/2010. Documentation received accounted for 2 units.</li> </ul>		

**E. Reimbursement**

(1) Billable Unit:

(a) Job Development is a single flat fee unit per ISP year payable once an individual is placed in a job.

(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:

- (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.

(c) Intensive Supported Employment services are 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.

(d) Group Supported Employment is a fifteen-

<p>minute unit.</p> <p>(e) Self-employment is a fifteen minute unit.</p> <p>(4) Billable Activities include:</p> <p>(a) Activities conducted within the scope of services;</p> <p>(b) Job development and related activities for up to ninety (90) calendar days) that result in employment of the individual for at least thirty (30) calendar days; and</p> <p>(c) Job development services shall not exceed ninety (90) calendar days, without written approval from the DDSD Regional Office.</p>			
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Tag # 5144 AH Reimbursement	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>A. General:</b> 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>B. Billable Units:</b> 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"> <li>(1) Date, start and end time of each service encounter or other billable service interval;</li> <li>(2) A description of what occurred during the encounter or service interval; and</li> <li>(3) The signature or authenticated name of staff providing the service.</li> </ol> <p><b>MAD-MR: 03-59 Eff 1/1/2004</b></p> <p><b>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b></p> <p>Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 XVI. REIMBURSEMENT</b></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 4 of 6 individuals.</p> <p>Individual #3 July 2010</p> <ul style="list-style-type: none"> <li>• The Agency billed 84 units of Adult Habilitation from 07/19/2010 through 07/25/2010. Documentation received accounted for 56 units.</li> </ul> <p>August 2010</p> <ul style="list-style-type: none"> <li>• The Agency billed 76 units of Adult Habilitation from 08/16/2010 through 08/22/2010. Documentation received accounted for 72 units.</li> </ul> <p>Individual #4 July 2010</p> <ul style="list-style-type: none"> <li>• The Agency billed 120 units of Adult Habilitation from 07/19/2010 through 07/25/2010. Documentation received accounted for 96 units.</li> </ul> <p>August 2010</p> <ul style="list-style-type: none"> <li>• The Agency billed 120 units of Adult Habilitation from 08/01/2010 through 08/08/2010. Documentation received accounted for 96 units.</li> </ul> <p>September 2010</p> <ul style="list-style-type: none"> <li>• The Agency billed 96 units of Adult Habilitation from 09/27/2010 through 09/30/2010. Documentation received accounted for 72 units.</li> </ul> <p>Individual #5 August 2010</p> <ul style="list-style-type: none"> <li>• The Agency billed 120 units of Adult Habilitation from 08/09/2010 through 08/15/2010. Documentation received accounted for 84 units.</li> </ul> <p>Individual #6 July 2010</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.

**B. Billable Activities**

(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.

(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

- The Agency billed 94 units of Adult Habilitation from 07/05/2010 through 07/11/2010. Documentation received accounted for 88 units.

August 2010

- The Agency billed 92 units of Adult Habilitation from 08/09/2010 through 08/15/2010. Documentation received accounted for 72 units

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</b></p> <p><b>G. Health Care Requirements for Community Living Services.</b></p> <p>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first.</p> <p>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <p>(a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>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 1 of 5 individuals receiving Community Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• <b>Abnormal Involuntary Movement Screening and/or Tardive Dyskinesia Screenings</b> <ul style="list-style-type: none"> <li>◦ None found 3/2010 - 6/2010 for Risperdal (#4)</li> </ul> </li> </ul>		

<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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Date: February 9, 2011  
To: Susan Karcz, Executive Director  
Provider: A Better Way of Living  
Address: 117 Montclair, SE  
State/Zip: Albuquerque, New Mexico 87108

E-mail Address: [susan@ABetterWayNM.org](mailto:susan@ABetterWayNM.org)

Region: Metro  
Survey Date: Month November 1 - 4, 2010  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Community Living (Supported Living) & Community Inclusion (Adult Habilitation & Supported Employment)  
Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Ms. Karcz,

Your request for a Reconsideration of Findings was received on January 27, 2011. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A09

Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, deficiencies noted in tag 1A09.1 regarding Individual #1 and 2 will be removed. The following findings will be modified; For Individual #3 missing Medication Administration Record (MAR) entries for Macrobid and Bactrim will be removed. For Individual #4 missing MAR July 2010 entries for Clonidine (pg. 14 of report of findings) will be removed; as will missing MAR August 2010 entries for Clonidine, Risperdone and Trazedone. Also removed are, for Individual #5, July and August 2010 MAR entries for Clonazepam and Clonidine. The remaining citations noted in this tag will be upheld. The scope and severity rating for this tag will be changed to an "E."

Regarding Tag # 1A09.1

Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, deficiencies noted in tag 1A09.1 regarding Individual #2 will be modified in the following way, MAR entries for August and September for Tylenol will be removed. For Individual #4, July, August and September MAR entries for Diphenhydram will be removed. The remaining citations noted in this tag were not disputed. The scope and severity rating for this tag will be changed to "D."

Regarding Tag # 1A20

Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the document request form specific to training and documents needed to demonstrate trainings had occurred were sufficient to support the removal of Participatory Communication and Choice Making (PCCM) for Individual #41. The remaining citations noted in tag 1A20 were not disputed. The scope and severity rating will remain "D."

Regarding Tag # 5I25

Determination: The IRF committee is removing the original finding in the report of findings.

Regarding Tag # 5I44

Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the request and documentation received the citation for Individual #4, September 2010 will be removed; Information supplied for Individual #3 was not sufficient for removal. The scope and severity rating for this tag will remain "B."

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

Thank you.  
Respectfully,



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