

Date: June 4, 2009

To: Jessica Martinez, Director
Provider: Active Solutions, Inc.
Address: 2730 San Pedro NE Suite H
State/Zip: Albuquerque, New Mexico 87110

CC: Todd D. Johnson, President
Address: 2730 San Pedro NE Suite H
State/Zip: Albuquerque, NM 87110

E-mail Address: jessicamartinez@activesolutionsinc.com

Region: Metro
Survey Date: April 13 – 16, 2009
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Independent Living & Family Living) & Community Inclusion (Adult Habilitation & Community Access)
Survey Type: Routine
Team Leader: Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Crystal Lopez-Beck, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Barbara Czinger, MSW, LISW, Healthcare Surveyor, Division of Health Improvement Quality Management Bureau
Survey #: Q09.04.A0991.METRO.001.RTN.01

Dear Ms. Martinez,

The Division of Health Improvement Quality Management Bureau has completed a quality review survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement.

Quality Management Approval Rating:

The Division of Health Improvement is granting your agency a "SUB-STANDARD" certification for your compliance with DDS Standards and regulations. Your agency will be referred to the Internal Review Committee.

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 900 Albuquerque, NM 87108
2. Developmental Disabilities Supports Division Regional Office for region of service surveyed.

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

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

Request for Informal Reconsideration of Findings (IRF):

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

QMB Deputy Bureau Chief
5301 Central Ave NE Suite #900
Albuquerque, NM 87108
Attention: IRF request

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

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

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

Please call the Team Leader at 505-222-8688 if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,



Nadine Romero, LBSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date: April 13, 2009

Present:

Active Solutions Inc.

Jessica Martinez, Director

DOH/DHI/QMB

Nadine Romero, LBSW, Team Lead/Healthcare Surveyor
Crystal Lopez-Beck, BS, Healthcare Surveyor
Barbara Czinger, MSW, LISW, Healthcare Surveyor

Exit Conference Date:

April 16, 2009

Present:

Active Solutions Inc.

Todd D. Johnson, Owner/President
Jessica Martinez, Director

DOH/DHI/QMB

Nadine Romero, LBSW, Team Lead/Healthcare Surveyor
Crystal Lopez-Beck, BS, Healthcare Surveyor
Barbara Czinger, MSW, LISW, Healthcare Surveyor

Homes Visited

Number: 8

Administrative Locations Visited

Number: 1

Total Sample Size

Number: 18
17 - Non Jackson
1 - Jackson Class Members
8 - Family Living
1 - Independent Living
4 - Adult Habilitation
13 - Community Access

Persons Served Interviewed

Number: 18

Persons Served Observed

Number: 18

Records Reviewed (Persons Served)

Number: 18

Administrative Files Reviewed

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

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

Attachment A

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

DHI Quality Review Survey Report – Active Solutions, Inc., Metro Region – April 13 – 16, 2009

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Report #: Q09.04.A0991.METRO.001.RTN.01

- 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 505-222-8624.
- 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 (505-841-5815), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been “Approved” or “Denied”.
- Whether your POC is “Approved” or “Denied”, you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is “Denied” it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- The following Deficiencies must be corrected within the deadlines below (after receipt of your Survey Report):
 - CCHS and EAR: 10 working days
 - Medication errors: 10 working days
 - IMS system/training: 20 working days
 - ISP related documentation: 30 working days
 - DDSD Training 45 working days
- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8624 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.
- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by-case basis.
- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual #s.
- Do not submit original documents, hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.

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

Attachment B

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

Key to Scope scale:

Isolated:

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

Pattern:

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

Widespread:

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

Key to Severity scale:

Low Impact Severity: (Blue)

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

Medium Impact Severity: (Tan)

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

High Impact Severity: (Green or Yellow)

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

High Impact Severity: (Yellow)

"J, K, and L" Level findings:

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

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) and must specify in detail the request for reconsideration and why the finding is inaccurate. **The IRF request must include all supporting documentation or evidence that was not previously reviewed during the survey process.**

The following limitations apply to the IRF process:

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

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

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

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

Administrative Review Process:

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

Regarding IRC Sanctions:

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

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

Agency: Active Solutions, Inc., - Metro Region
Program: Developmental Disabilities Waiver
Service: Community Living (Family Living & Independent Living) & Community Inclusion (Adult Habilitation & Community Access)
Monitoring Type: Routine
Date of Survey: April 13 - 16, 2009

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<p>Tag # 1A08 Agency Case File</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</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>Scope and Severity Rating: A</p> <p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 1 of 18 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"> • Positive Behavioral Plan (#18) • Positive Behavior Crisis Plan (#18) 		

<ul style="list-style-type: none"> (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (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 (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: <ul style="list-style-type: none"> (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital. 			
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Tag # 1A09 Medication Delivery (MAR)	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <ol style="list-style-type: none"> The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; Prescribed dosage, frequency and method/route of administration, times and dates of administration; Initials of the individual administering or assisting with the medication; Explanation of any medication irregularity; Documentation of any allergic reaction or adverse medication effect; and For PRN medication, an explanation for the use of the PRN medication shall include 	<p>Medication Administration Records (MAR) were reviewed for the months of January, February and March, 2009. The following MARs contained missing medications entries and/or other errors:</p> <p>Based on record review, 6 of 8 individuals had Medication Administration Records, which contained missing medications entries and /or other errors:</p> <p>Individual # 3 December 2008</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> Tegretol 400 mg (2 times daily) Phenobarbital 75 mg (1 time daily) Phenobarbital 90 mg (1 time daily) Ocuflox Eye drop (1 time daily) Ciloxan (1 time daily) Prevident Tooth Gel (1 time daily) Nasonex Nasal Spray (1 time daily) Metamucil 5 mg (2 times daily) Lactulose 15 cc (2 times daily) Prozac 10 mg (1 time daily) Astelin Nasal Spray (1 time daily) <p>January 2009</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> Tegretol 400 mg (2 times daily) Phenobarbital 75 mg (1 time daily) Phenobarbital 90 mg (1 time daily) Ocuflox Eye drop (1 time daily) Ciloxan (1 time daily) Prevident Tooth Gel (1 time daily) Nasonex Nasal Spray (1 time daily) Metamucil 5 mg (2 times daily) Lactulose 15 cc (2 times daily) Prozac 10 mg (1 time daily) 		

<p>observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; 	<ul style="list-style-type: none"> • Astelin Nasal Spray (1 time daily) <p>February 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Tegretol 400 mg (2 times daily) • Phenobarbital 75 mg (1 time daily) • Phenobarbital 90 mg (1 time daily) • Ocuflax Eye drop (1 time daily) • Ciloxan (1 time daily) • Prevident Tooth Gel (1 time daily) • Nasonex Nasal Spray (1 time daily) • Metamucil 5 mg (2 times daily) • Lactulose 15 cc (2 times daily) • Prozac 10 mg (1 time daily) • Astelin Nasal Spray (1 time daily) <p>Individual # 9 December 2008 Medication Administration Record does not contain a full signature that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following:</p> <ul style="list-style-type: none"> • Topamax 100 mg (2 times daily) • Dilantin 100 mg (2 times daily) • Klonopin 0.5 mg (2 times daily) • Actonel 35 mg (take one every Tuesday) <p>No time taken indicated on the Medication Administration Record document for the following medication, MAR indicated time as "A.M.":</p> <ul style="list-style-type: none"> • Klonopin 0.5 mg (2 times daily) <p>January 2009 Medication Administration Record does not contain a full signature that designates the full name that corresponds to each initial used to document administered or assisted delivery of</p>		
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<p>(x) The name and initials of all staff administering medications.</p> <p>Model Custodial Procedure Manual D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> ➤ symptoms that indicate the use of the medication, ➤ exact dosage to be used, and ➤ the exact amount to be used in a 24 hour period. 	<p>each dose for the following:</p> <ul style="list-style-type: none"> • Topamax 100 mg (2 times daily) • Dilantin 100 mg (2 times daily) • Klonopin 0.5 mg (2 times daily) • Actonel 35 mg (take one every Tuesday) <p>No time taken indicated on the Medication Administration Record document for the following medication, MAR indicated time as "A.M.":</p> <ul style="list-style-type: none"> • Klonopin 0.5 mg (2 times daily) <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Topamaz 100 mg (2 times daily) - Blank - January 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 26, 27, 28, 29, 30 & 31 (6 AM) <p>February 2009 Medication Administration Record does not contain a full signature that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following:</p> <ul style="list-style-type: none"> • Topamax 100 mg (2 times daily) • Dilantin 100 mg (2 times daily) • Klonopin 0.5 mg (2 times daily) • Actonel 35 mg (take one every Tuesday) <p>Individual # 10 December 2008 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Ibuprofen 600 mg (3 times daily for 10 days) <p>January 2009 Medication Administration Records did not</p>		
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	<p>contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Doxycycline 100 mg (2 times daily for 10 days) <p>Individual # 15 December 2008 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Pepcid 20 mg (Take every 12 hours until finished) • Prednizone 10 mg <p>Medication Administration Record indicated medication was to taken as follows:</p> <ul style="list-style-type: none"> • Prednizone 10 mg (2 tablets daily for 3 days, then 1 tablet daily for 3 days) Per Physician orders medication is to be takes as follows: 6 tablets daily for 3 days, then 4 tablets daily for 3 days , then 2 tablets daily for 3 days & finally 1 tablet daily for 3 days. MAR and Physician orders do not match. <p>Individual # 16 December 2008 Medication Administration Record indicated medication had not been given as prescribed:</p> <ul style="list-style-type: none"> • Ibuprofen 800 mg – 3 times daily for 7 days. MAR only contained dates for 6 days. December 3, 4, 5, 6, 7 & 28. • Ciprofloxacin 500 mg – 2 times daily for 10 days. MAR indicated the individual was given an extra dose on December 15, 2008. <p>January 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Citalopram - 40 mg - Blank - January 3, 4 & 5 (9AM) • Citalopram - 20 mg - Blank - January 3 & 4 (1PM) 		
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	<ul style="list-style-type: none"> • Citalopram 10 mg - Blank - January 3 & 4 (1PM) <p>Medication Administration Record indicated medication had not been given as prescribed:</p> <ul style="list-style-type: none"> • Ibuprofen 800 mg – 3 times daily for 7 days. MAR indicated medication had been give for 9 days: January 23, 24, 25, 26, 27, 28, 29, 30 & 31 <p>Individual # 17 December 2008</p> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Topamax 200 mg - 2 times daily <p>Medication Administration Records did not contain diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Topamax 200 mg - 2 times daily 		
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Tag # 1A09 Medication Delivery - PRN	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 DDS Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</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>NMAC 16.19.11.8 MINIMUM STANDARDS:</p> <p>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> <p>(i) Name of resident;</p>	<p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 4 of 8 Individuals.</p> <p>Individual # 4 December 2008 No symptoms noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Tylenol (PRN) - December 1 & 5, 2008. • Benadryl (PRN) – December 2, 9 &17, 2008 <p>No effectiveness noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Tylenol (PRN) – December 1 & 5, 2008. • Benadryl (PRN) – December 2, 9 &17, 2008 <p>February 2009 No symptoms noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Benadryl (PRN) – February 18, 19, 22 & 23, 2009 <p>Individual # 9 December 2008 Medication Administration Record does 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:</p> <ul style="list-style-type: none"> • Ativan - 2mg (PRN) <p>January 2009 Medication Administration Record document does 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:</p> <ul style="list-style-type: none"> • Ativan - 2mg (PRN) 		

<ul style="list-style-type: none"> (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. <p>Model Custodial Procedure Manual D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> ➤ symptoms that indicate the use of the medication, ➤ exact dosage to be used, and ➤ the exact amount to be used in a 24 hour period. 	<p>February 2009 Medication Administration Record document does 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:</p> <ul style="list-style-type: none"> • Ativan - 2mg (PRN) <p>Individual # 15 December 2008 Medication Administration Records did not contain the circumstance in which the medication is to be given:</p> <ul style="list-style-type: none"> • Hydroxyzine 25mg (PRN) <p>Individual # 16 December 2008 No effectiveness noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Phenazopyridine 200mg (PRN) - December 5, 6, 7, 8 & 9 		
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Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>(1) Documentation of nursing assessment activities</p> <p>(a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training:</p> <ul style="list-style-type: none"> (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. <p>(b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so.</p>	<p>Based on record review the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 2 of 18 individuals.</p> <p>The following were not found or not current:</p> <ul style="list-style-type: none"> • Medication Administration Assessment Tool (#6) • Crisis Plans <ul style="list-style-type: none"> ◦ Cardiac condition (#6) (Per IST section of the ISP the individual requires a crisis plan) ◦ Seizures (#9) (Per IST section of the ISP the individual requires a crisis plan) ◦ Asthma (#9) (Per IST section of the ISP the individual requires a crisis plan) ◦ Allergy (#9) (Per IST section of the ISP the individual requires a crisis plan) 		

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

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

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

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

(2) Health related plans

(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention

and intervention plan must be written by the nurse or other appropriately designated healthcare professional.

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

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

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

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

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

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

(c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and

designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan.

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

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

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

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

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

(4) General Nursing Documentation

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

(b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current

health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</p> <p>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 25 of 65 Direct Service Personnel.</p> <p>Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> • Pre- Service (DSP #83, 88, 97, 101, 102, 107, 108, 109, 113 & 114) • Basic Health/Orientation (DSP #70, 88, 89, 97, 101, 102, 108, 109, 112, 113 & 114) • Person-Centered Planning (1-Day) (DSP #70, 76, 100, 105, 109, 113 & 114) • First Aid (DSP # 61, 65& 114) • CPR (DSP # 65 & 114) • Assisting With Medications (DSP #51, 54, 57 & 93) • Rights & Advocacy (DSP #103, 105, 109, 112 & 113) • Level 1 Health (DSP #73, 103, 105, 109, 111, 112 &113) • Teaching & Support Strategies (DSP #73, 103, 105, 109 & 113) • Positive Behavior Supports Strategies (DSP #103, 105, 109, 111 & 113) • Participatory Communication & Choice Making (DSP #73, 103, 105, 109, 112 & 113) 		

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D		
<p>NMAC 7.1.9.9 A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</p> <p>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: A. homicide; B. trafficking, or trafficking in controlled substances; C. kidnapping, false imprisonment, aggravated assault or aggravated battery; D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; E. crimes involving adult abuse, neglect or financial exploitation; F. crimes involving child abuse or neglect; G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p> <p>Chapter 1.IV. General Provider Requirements. D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.</p>	<p>Based on record review, the Agency failed to maintain documentation indicating "no disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 7 of 71 Agency Personnel.</p> <ul style="list-style-type: none"> • # 53 – Date of Hire 10/24/06 • # 87 – Date of Hire 9/22/08 • # 93 – Date of Hire 3/15/07 • # 115 – Date of Hire 12/18/06 • # 116 – Date of Hire 7/31/06 • # 118 – Date of Hire 10/15/07 • # 120 – Date of Hire 7/15/08 		

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E		
<p>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p>	<p>Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced the inquiry to the Employee Abuse Registry prior to employment for 37 of 71 Agency Personnel.</p> <ul style="list-style-type: none"> • #50 - Date of Hire 10/20/06 • #51 - Date of Hire 8/31/07 • #55 - Date of Hire 3/15/07 • #56 - Date of Hire 7/1/08 • #58 - Date of Hire 12/1/07 • #59 - Date of Hire 31/1/07 • #60 - Date of Hire 5/30/07 • #62 - Date of Hire 11/2/06 • #63 - Date of Hire 3/30/07 • #65 - Date of Hire 8/3/07 • #66 - Date of Hire 3/6/08 • #69 - Date of Hire 11/1/06 • #70 - Date of Hire 11/5/08 • #71 - Date of Hire 3/27/07 • #72 - Date of Hire 2/8/08 • #73 - Date of Hire 10/1/07 • #74 - Date of Hire 4/2/08 • #76 - Date of Hire 4/30/08 • #77 - Date of Hire 9/1/08 • #78 - Date of Hire 7/31/08 • #79 - Date of Hire 5/1/06 • #80 - Date of Hire 12/7/07 • #81 - Date of Hire 1/4/07 • #82 - Date of Hire 1/28/06 • #91 - Date of Hire 2/14/06 • #93 - Date of Hire 3/15/07 • #95 - Date of Hire 4/1/09 • #96 - Date of Hire 3/14/08 • #98 - Date of Hire 7/1/06 • #104 - Date of Hire 6/18/08 • #105 - Date of Hire 1/8/08 • #109 - Date of Hire 3/15/07 • #114 - Date of Hire 5/15/08 • #116 - Date of Hire 12/18/06 		

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

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.

- #118 - Date of Hire 10/15/07
- #120 - Date of Hire 7/15/08

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: D		
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</p>	<p>Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 2 of 71 Agency Personnel.</p> <ul style="list-style-type: none"> • Abuse, Neglect & Exploitation (#96) <p>When DSP were asked what two State Agencies is suspected Abuse, Neglect and Exploitation reported to, the following was reported:</p> <ul style="list-style-type: none"> • DSP #105 stated, "Fill out form, call team." DSP did not identify they are required to report the Adult Protective Service and/or the Division of Health Improvement. 		

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</p>	<p>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 5 of 71 Agency Personnel.</p> <ul style="list-style-type: none"> • Individual Specific Training (#81, 83, 85, 92 & 97) 		

Tag # 5I36 CA Reimbursement	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS</p> <p>G. Reimbursement</p> <p>(1) Billable Unit: A billable unit is defined as one-quarter hour of service.</p> <p>(2) Billable Activities: The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions:</p> <p>(a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan;</p> <p>(b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and</p> <p>(c) Non face-to-face hours do not exceed 10% of the monthly billable hours.</p> <p>(3) Non-Billable Activities: Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include:</p> <p>(a) Time and expense for training service personnel;</p> <p>(b) Supervision of agency staff;</p> <p>(c) Service documentation and billing activities; or</p> <p>(d) Time the individual spends in segregated facility-based settings activities.</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for 3 of 13 individuals receiving Community Access Services.</p> <p>Individual # 1</p> <ul style="list-style-type: none"> January 2009 - Agency billed 88 units of Community Access. Documentation received accounted for 64 units. <p>Individual # 8</p> <ul style="list-style-type: none"> February 2009 - Agency billed 16 units of Community Access. No documentation found to justify billing. <p>Individual # 15</p> <ul style="list-style-type: none"> December 2008 - Agency billed 140 units of Community Access. Documentation received accounted for 114 units. January 2009 - Agency billed 182 units of Community Access. Documentation received accounted for 162 units. 		

Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: F		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES</p> <p>B. Home Studies. The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD.</p>	<p>Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 7 of 8 individuals.</p> <ul style="list-style-type: none"> • DDSD Approval for Subcontractor (#3, 4, 9, 10, 15, 16 & 17) 		

Tag # 6L14 Residential Case File	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 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</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 2 of 8 Individuals receiving Family Living Services.</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification <ul style="list-style-type: none"> ◦ Not Current (#4) ◦ No Pharmacy Identified (#16) • Addendum A (#16) • Speech Therapy Plan (#4) • Health Care Providers Written Orders (#16) 		

least the past month;

(7) Physician's or qualified health care providers written orders;

(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);

(9) Medication Administration Record (MAR) for the past three (3) months which includes:

- (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:
 - (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.

(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

(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.