



Alfredo Vigil, MD
Secretary

DEPARTMENT OF

Building a Healthy New Mexico!

Bill Richardson, Governor

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Deputy Secretary

Duffy Rodriguez
Deputy Secretary

Jessica Sutin
Deputy Secretary

Karen Armitage, MD
Chief Medical Officer

Date: June 29, 2009

To: Richard Barbaras, Chief Executive Officer
Provider: Zia Therapy Center, Inc.
Address: 900 First Street
State/Zip: Alamogordo, NM

CC: Michael Dorame, Board Chair
Address: 110 Encino
State/Zip: Tularosa, NM 88352

E-mail Address: rbarb@ziatherapy.org
Admin@ziatherapy.org

Region: Southwest
Survey Date: May 11 - 13, 2009
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Survey Type: Routine
Team Leader: Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Cyndie Nielsen, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau;

Dear Mr. Barbaras,

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 "STANDARD" certification for basic compliance with DDSD Standards and regulations.

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.

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

David Rodriguez, Division Director • Division of Health Improvement

Division of Health Improvement • Quality Management Bureau • 5301 Central Ave NE • Suite 900 • Albuquerque, New Mexico 87108
(505) 222-8623 • FAX: (505) 841-5815

DHI Quality Review Survey Report – Zia Therapy Center, Inc. SW Region – May 11 – 13, 2009

Report #: Q09.04.D1644.SW.001.RTN.01

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 505-690-4693, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,



Deb Russell
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date: May 11, 2009

Present: **Zia Therapy Center, Inc.**
Sherill Bodveel, Chief Operations Officer
Renee Shaffer, Supported Employment Coordinator
Janet Wood, Day Hab Supervisor
Barbara House, Adult Services Manager
John Stewart, Family Living Service Coordinator
Esmeralda Loewer, Administration

DOH/DHI/QMB

Deb Russell, BS, Team Lead/Healthcare Surveyor
Cyndie Nielsen, RN, MSN, Healthcare Surveyor

Exit Conference Date: May 13, 2009

Present: **Zia Therapy Center, Inc.**
Richard Barbaras, Chief Executive Officer
Milt Jones, Board Member, Family Living Provider
Sharon Gilsdorf, Chief Financial Officer
Larry Weber, Training Coordinator
Fern Ellis, Secretary
Shaughnessy "Shauna" Pitzer, Licensed Practical Nurse
Renee Shaffer, Supported Employment Coordinator
Janet Wood, Day Hab Supervisor
Barbara House, Adult Services Manager
John Stewart, Family Living Service Coordinator
Esmeralda Loewer, Administration

DOH/DHI/QMB

Deb Russell, BS, Team Lead/Healthcare Surveyor
Cyndie Nielsen, RN, MSN, Healthcare Surveyor

DDSD - Southwest Regional Office

Randy Cahall, RN (Via Teleconference)

Homes Visited Number: 3

Administrative Locations Visited Number: 1

Total Sample Size Number: 7
0 - Jackson Class Members
7 - Non-Jackson Class Members
4 - Family Living
6 - Adult Habilitation
3 - Supported Employment
3 - Community Access

Persons Served Interviewed Number: 5

Persons Served Observed Number: 2 (Two individuals were not available during the on-site visits)

Records Reviewed (Persons Served) Number: 7

Administrative Files Reviewed

- Billing Records
- Medical Records

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

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

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8624.
- 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.

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

Key to Scope scale:

Isolated:

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

Pattern:

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

Widespread:

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

Key to Severity scale:

Low Impact Severity: (Blue)

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

Medium Impact Severity: (Tan)

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

High Impact Severity: (Green or Yellow)

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

High Impact Severity: (Yellow)

“J, K, and L” Level findings:

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

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

Introduction:

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

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

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

The following limitations apply to the IRF process:

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

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

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

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

Administrative Review Process:

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

Regarding IRC Sanctions:

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

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

Agency: Zia Therapy Center, Inc. - Southwest Region
Program: Developmental Disabilities Waiver
Service: Community Living (Family Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Routine Survey
Date of Survey: May 11 – 13, 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>(2) The individual's complete and current ISP, with</p>	<p>Scope and Severity Rating: B</p> <p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 4 of 7 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • ISP Signature Page (#2) • Addendum A (#2 & 5) • Physical Therapy Plan (#3 & 7) 		

<p>all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);</p> <p>(3) Progress notes and other service delivery documentation;</p> <p>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</p> <p>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <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: F		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <ol style="list-style-type: none"> The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; Prescribed dosage, frequency and method/route of administration, times and dates of administration; Initials of the individual administering or assisting with the medication; Explanation of any medication irregularity; Documentation of any allergic reaction or adverse medication effect; and For PRN medication, an explanation for the 	<p>Medication Administration Records (MAR) were reviewed for the months of February, March & April 2009.</p> <p>Based on record review, 4 of 4 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #1 February 2009 Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Ranitidine 150 mg (2 times daily) • Ativan 0.5 mg (2 times daily) • Risperdal 1 mg (2 time daily) • Lexapro 20 mg (1 time daily) • Gemfibrozil 600 mg (2 times daily) • Depakote 500 mg (1 time daily) <p>March 2009 Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Ranitidine 150 mg (2 times daily) • Ativan 0.5 mg (2 times daily) • Risperdal 1 mg (2 time daily) • Lexapro 20 mg (1 time daily) • Gemfibrozil 600 mg (2 times daily) • Depakote 500 mg (1 time daily) 		

<p>use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. 	<p>April 2009 Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Ranitidine 150 mg (2 times daily) • Ativan 0.5 mg (2 times daily) • Risperdal 1 mg (2 time daily) • Lexapro 20 mg (1 time daily) • Gemfibrozil 600 mg (2 times daily) • Depakote 500 mg (1 time daily) <p>Individual #2 February 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Gemfribrozil (2 times daily) • Multi-Vitamin (1 time daily) • Fish Oil (1 time daily) <p>Medication Administration Records did not contain the dosage of the medication, which is to be given:</p> <ul style="list-style-type: none"> • Gemfribrozil (2 times daily) • Multi-Vitamin (1 time daily) • Fish Oil (1 time daily) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Gemfribrozil (2 times daily) • Multi-Vitamin (1 time daily) 		
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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.

- Fish Oil (1 time daily)

Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:

- Gemfibrozil (2 times daily)
- Multi-Vitamin (1 time daily)

March 2009

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

- Gemfibrozil (2 times daily)
- Multi-Vitamin (1 time daily)
- Fish Oil (1 time daily)

Medication Administration Records did not contain the dosage of the medication, which is to be given:

- Gemfibrozil (2 times daily)
- Multi-Vitamin (1 time daily)
- Fish Oil (1 time daily)

Medication Administration Records did not contain the route of administration for the following medications:

- Gemfibrozil (2 times daily)
- Multi-Vitamin (1 time daily)
- Fish Oil (1 time daily)

Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:

- Gemfibrozil (2 times daily)

	<ul style="list-style-type: none"> • Multi-Vitamin (1 time daily) <p>April 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Gemfibrozil (2 times daily) • Multi-Vitamin (1 time daily) • Fish Oil (1 time daily) <p>Medication Administration Records did not contain the dosage of the medication, which is to be given:</p> <ul style="list-style-type: none"> • Gemfibrozil (2 times daily) • Multi-Vitamin (1 time daily) • Fish Oil (1 time daily) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Gemfibrozil (2 times daily) • Multi-Vitamin (1 time daily) • Fish Oil (1 time daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Gemfibrozil (2 times daily) • Multi-Vitamin (1 time daily) <p>Individual #3 February 2009 Medication Administration Records did not contain the diagnosis for which the medication is</p>		
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	<p>prescribed:</p> <ul style="list-style-type: none"> • Levothyroxine 0.05 mg (1 time daily) • Fluoxetine 10 mg (1 time daily) • Etodolac 200 mg (2 times daily) • Gabapentin 600 mg (3 times daily) • Prilosec 25 mg (1 time daily) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxine 0.05 mg (1 time daily) • Fluoxetine 10 mg (1 time daily) • Etodolac 200 mg (2 times daily) • Gabapentin 600 mg (3 times daily) • Prilosec 25 mg (1 time daily Medication <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Levothyroxine 0.05 mg (1 time daily) • Fluoxetine 10 mg (1 time daily) • Etodolac 200 mg (2 times daily) • Gabapentin 600 mg (3 times daily) • Prilosec 25 mg (1 time daily <p>March 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p>		
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	<ul style="list-style-type: none"> • Levothyroxine 0.05 mg (1 time daily) • Fluoxetine 10 mg (1 time daily) • Etodolac 200 mg (2 times daily) • Gabapentin 600 mg (3 times daily) • Prilosec 25 mg (1 time daily) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Levothyroxine 0.05 mg (1 time daily) • Fluoxetine 10 mg (1 time daily) • Etodolac 200 mg (2 times daily) • Gabapentin 600 mg (3 times daily) • Prilosec 25 mg (1 time daily Medication <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Levothyroxine 0.05 mg (1 time daily) • Fluoxetine 10 mg (1 time daily) • Etodolac 200 mg (2 times daily) • Gabapentin 600 mg (3 times daily) • Prilosec 25 mg (1 time daily) <p>April 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Fluoxetine 10 mg (1 time daily) 		
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	<ul style="list-style-type: none"> • Etodolac 200 mg (2 times daily) • Gabapentin 600 mg (3 times daily) • Prilosec 25 mg (1 time daily) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Fluoxetine 10 mg (1 time daily) • Etodolac 200 mg (2 times daily) • Gabapentin 600 mg (3 times daily) • Prilosec 25 mg (1 time daily Medication <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Fluoxetine 10 mg (1 time daily) • Etodolac 200 mg (2 times daily) • Gabapentin 600 mg (3 times daily) • Prilosec 25 mg (1 time daily <p>Individual #4 February 2009</p> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Depakote ER 500 mg (2 times daily) • Protonix 40 mg (1 time daily) • Sal-tropine .4 mg (2 times daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of</p>		
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	<p>medication to be taken for the following:</p> <ul style="list-style-type: none"> • Depakote ER 500 mg (2 times daily) • Protonix 40 mg (1 time daily) • Sal-tropine .4 mg (2 times daily) <p>March 2009</p> <p>Medication Administration Records did not contain the dosage of the medication, which is to be given:</p> <ul style="list-style-type: none"> • Azithromycin (1 time daily) • Mucinex (3 times daily) • Ciproflaxin (2 times daily) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Depakote ER 500 mg (2 times daily) • Protonix 40 mg (1 time daily) • Sal-tropine .4 mg (2 times daily) • Azithromycin (1 time daily) • Mucinex (3 times daily) • Ciproflaxin (3 times daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Depakote ER 500 mg (2 times daily) • Protonix 40 mg (1 time daily) • Sal-tropine .4 mg (2 times daily) 		
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	<ul style="list-style-type: none"> • Azithromycin (1 time daily) • Mucinex (3 times daily) • Ciproflaxin (3 times daily) <p>April 2009 Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Depakote ER 500 mg (2 times daily) • Protonix 40 mg (1 time daily) • Sal-tropine .4 mg (2 times daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Depakote ER 500 mg (2 times daily) • Protonix 40 mg (1 time daily) • Sal-tropine .4 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 DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <ol style="list-style-type: none"> The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; Prescribed dosage, frequency and method/route of administration, times and dates of administration; Initials of the individual administering or assisting with the medication; Explanation of any medication irregularity; Documentation of any allergic reaction or adverse medication effect; and For PRN medication, an explanation for the 	<p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 2 of 4 Individuals.</p> <p>Individual #2 February 2009</p> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Zicam (PRN) • Saline Nasal Gel (PRN) • Pepto Bismol (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be given:</p> <ul style="list-style-type: none"> • Zicam (PRN) • Saline Nasal Gel (PRN) • Pepto Bismol (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Zicam (PRN) • Saline Nasal Gel (PRN) • Pepto Bismol (PRN) <p>April 2009</p> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Zicam (PRN) • Saline Nasal Gel (PRN) 		

<p>use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006</p> <p>F. PRN Medication</p> <p>3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by</p>	<ul style="list-style-type: none"> • Pepto Bismol (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be given:</p> <ul style="list-style-type: none"> • Zicam (PRN) • Saline Nasal Gel (PRN) • Pepto Bismol (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Zicam (PRN) • Saline Nasal Gel (PRN) • Pepto Bismol (PRN) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Zicam – PRN – 4/22 & 25 (given 1 time daily) <p>Individual #4 February 2009</p> <p>Medication Administration Records did not contain the exact amount to be used in a 24-hour period:</p> <ul style="list-style-type: none"> • Valium (PRN) • Motrin 400 mg (PRN) <p>Medication Administration Records did not contain the prescribed dosage in which the medication is to be given:</p> <ul style="list-style-type: none"> • Valium (PRN) <p>Medication Administration Records did not contain the circumstance for which the</p>		
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<p>consanguinity to the individual.</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. <p>Model Custodial Procedure Manual D. Administration of Drugs</p> <p>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>medication is to be given:</p> <ul style="list-style-type: none"> • Valium (PRN) • Motrin 400 mg (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Valium (PRN) • Motrin 400 mg (PRN) <p>March 2009</p> <p>Medication Administration Records did not contain the exact amount to be used in a 24-hour period:</p> <ul style="list-style-type: none"> • Tylenol Sinus (PRN) • Motrin 400 mg (PRN) • Tylenol (PRN) • Levaquin (PRN) <p>Medication Administration Records did not contain the strength of the medication to be given:</p> <ul style="list-style-type: none"> • Tylenol Sinus (PRN) • Tylenol (PRN) • Levaquin (PRN) <p>Medication Administration Records did not contain the circumstance for which the medication is to be given:</p> <ul style="list-style-type: none"> • Tylenol Sinus (PRN) • Motrin 400 mg (PRN) • Tylenol (PRN) 		
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	<ul style="list-style-type: none"> •Levaquin (PRN) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> •Tylenol Sinus(PRN) •Motrin 400 mg (PRN) •Tylenol (PRN) •Levaquin (PRN) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> •Motrin 400 mg – PRN – 3/11 (given 1 time daily) •Tylenol – PRN – 3/24 & 24 (given 1 time daily) •Levaquin – PRN – 3/25 (given 1 time daily) •Ipratropium 60/2.5 – PRN – 3/12, 13, 14, 15, 25, 26, 27, 28, 29, 30 & 31 (given 1 time daily) 		
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Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>(1) Documentation of nursing assessment activities</p> <p>(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</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 1 of 4 individuals.</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Abnormal Involuntary Movement Screening and/or Tardive Dyskinesia Screenings <ul style="list-style-type: none"> ◦ Individual #1 - None found 5/2008 – 4/2009. Individual takes Risperdal. 		

complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. 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

<p>intervention plan must be written by the nurse or other appropriately designated healthcare professional.</p> <p>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.</p> <p>(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.</p> <p>(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.</p> <p>(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):</p> <p>(a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.</p> <p>(b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.</p> <p>(c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family</p>			
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<p>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.</p> <p>(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.</p> <p>(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.</p> <p>(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.</p> <p>(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.</p> <p>(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.</p> <p>(4) General Nursing Documentation</p> <p>(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.</p> <p>(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.</p>			
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Tag # 1A20 DSP Training Documents	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> <ol style="list-style-type: none"> (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 (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>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 2 of 21 Direct Service Personnel.</p> <p>Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> • Person-Centered Planning (1-Day) (DSP #55) • Rights & Advocacy (DSP #49) • Positive Behavior Supports Strategies (DSP #49) 		

Tag # 1A22 Staff Competence	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>F. Qualifications for Direct Service Personnel: The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</p> <ol style="list-style-type: none"> (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy 	<p>Based on interview, the Agency failed to ensure that training competencies were met for 1 of 11 Direct Service Personnel.</p> <p>When DSP were asked if they received training on the Individual's Speech Therapy Plan, the following was reported:</p> <ul style="list-style-type: none"> • DSP #59 stated, "I think she has it." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #6) 		

<p>Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and</p> <p>(5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support.</p> <p>(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:</p> <p>(a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services;</p> <p>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</p> <p>(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p>			
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Tag # 1A28 (CoP) Incident Mgt. System - Posters	Scope & Severity Rating: E		
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>F. Posting of Incident Management Information Poster: All licensed health care facilities and community based service providers shall post two (2) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. All licensed health care facilities and community based service providers operating sixty (60) or more beds shall post three (3) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. The posters shall be posted where employees report each day and from which the employees operate to carry out their activities. Each licensed health care facility or community based service provider shall take steps to insure that the notices are not altered, defaced, removed, or covered by other material. [7.1.13.10 NMAC - N, 02/28/06]</p>	<p>Based on observation, the Agency failed to post two (2) or more Incident Management Information posters in a prominent public location for the following locations for 2 of 3 residences:</p> <p>The following locations were identified:</p> <p>Residence of :</p> <ul style="list-style-type: none"> • Individual #1 & 2 		

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</p> <p>PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDS) Policy</p> <p>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications</p>	<p>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 1 of 24 Agency Personnel.</p> <p>Review of personnel records found no evidence of the following:</p> <ul style="list-style-type: none"> • Individual Specific Training (#55) 		

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 DDS-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDS-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 DDS-approved medication course in accordance with the DDS 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. The training shall address at least the following:

1. Operating a fire extinguisher
2. Proper lifting procedures
3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat)
4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines)

<p>for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)</p> <p>5. Operating wheelchair lifts (if applicable to the staff's role)</p> <p>6. Wheelchair tie-down procedures (if applicable to the staff's role)</p> <p>7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)</p>			
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Tag # 5I22 SE Agency Case File	Scope and Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</p> <p>D. Provider Agency Requirements</p> <p>(1) Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDSD. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.</p> <p>(2) The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items:</p> <p>(a) Quarterly progress reports;</p> <p>(b) Vocational assessments (A vocational assessment or profile is an objective analysis of a person's interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDSD;</p> <p>(c) Career development plan as incorporated in the ISP; a career development plan consists of the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks</p>	<p>Based on record review, the Agency failed to maintain a confidential case file for each individual for 1 of 3 individuals receiving Supported Employment Services.</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Required Certificates & Documentation (#5) 		

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

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

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

Policy Title: Vocational Assessment Profile

Policy Eff July 16, 2008

I. PURPOSE

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

II. POLICY STATEMENT

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

Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES</p> <p>B. Home Studies. The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS</p> <p>D. Scope of DDSD Agreement</p> <p>(4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite;</p> <p>NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER</p> <p>ELIGIBLE PROVIDERS:</p> <p>I. Qualifications for community living service providers: There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service</p>	<p>Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 1 of 4 individuals.</p> <ul style="list-style-type: none"> • Family Living (Initial) Home Study (#2) 		

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

Tag # 6L14 Residential Case File	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>A. Residence Case File: For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:</p> <p>(1) Complete and current ISP and all supplemental plans specific to the individual;</p> <p>(2) Complete and current Health Assessment Tool;</p> <p>(3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;</p> <p>(4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);</p> <p>(5) Data collected to document ISP Action Plan implementation</p> <p>(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 2 of 3 Individuals receiving Family Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Addendum A (#2) • Speech Therapy Plan (#3) • Physical Therapy Plan (#3) • Health Care Providers Written Orders (#2) 		

<p>least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: <ul style="list-style-type: none"> (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. <p>(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current</p>			
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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.

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

ADDITIONAL FINDINGS: Reimbursement Deficiencies

**BILLING
TAG #1A12**

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION**

B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:

- (1) Date, start and end time of each service encounter or other billable service interval;
- (2) A description of what occurred during the encounter or service interval; and
- (3) The signature or authenticated name of staff providing the service.

Billing for Community Living (Family Living) and Community Inclusion (Adult Habilitation, Community Access & Supported Employment) services was reviewed for 7 of 7 individuals. Progress notes and billing records supported billing activities for the months of January, February & March 2009.