



Alfredo Vigil, MD
Secretary

DEPARTMENT OF

Building a Healthy New Mexico!

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Deputy Secretary

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Deputy Secretary

Karen Armitage, MD
Chief Medical Officer

Date: January 28, 2009

To: Michael R. Buszek, PhD, Executive Director,
Provider: Transitional Lifestyles Community, Inc.
Address: 11000 Spain Rd. NE Building D
State/Zip: Albuquerque, New Mexico 87111

CC: Terry Mosley, Board Chair
Address: 11000 Spain Rd. NE Building D
State/Zip: Albuquerque, New Mexico 87111

Region: Metro
Dates of Original Survey: June 23 - 26, 2008
Dates of Follow-Up Survey: December 8 – 11, 2008
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living & Family Living)
Survey Type: Plan of Correction Follow-up

Team Leader: Nadine Romero, LBSW, Health Care Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Florie Alire, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Cynthia Nielsen, MSN, RN, ONC, CCM, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Report #: Q09.02.D3235.METRO.002.FU.02

Dear Dr. Buszek,

The Division of Health Improvement Quality Management Bureau has completed a Plan of Correction Follow-up survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI/DDSD regarding the routine survey on June 23 - 26, 2008.

These findings will be reviewed by the DOH – Internal Review Committee during an upcoming review meeting. The findings are attached.

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.

DHI Quality Review Survey Report – Transitional Lifestyles Community, Metro – December 8 – 11, 2008 1

Report #: Q09.02.D3235.METRO.002.FU.02

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,

A handwritten signature in black ink that reads "Nadine Romero, LBSW". The signature is written in a cursive, flowing style.

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

Survey Process Employed:

Entrance Conference Date: December 8, 2008

Present: **Transitional Lifestyles Community, Inc.**
Terry L. Mosley, Vice President

DOH/DHI/QMB

Nadine Romero, LBSW, Team Lead/Healthcare Surveyor
Marti Madrid, LBSW, Healthcare Surveyor
Florie Alire, RN, Healthcare Surveyor
Cynthia Nielsen, MSN, RN, ONC, CCM, Healthcare Surveyor

Exit Conference Date: December 11, 2008

Present: **Transitional Lifestyles Community, Inc.**
Michael R. Buszek, PhD. CEO/President
Terry L. Mosley, Vice President

DOH/DHI/QMB

Nadine Romero, LBSW, Team Lead/Healthcare Surveyor
Florie Alire, RN, Healthcare Surveyor
Cynthia Nielsen, MSN, RN, ONC, CCM, Healthcare Surveyor

Homes Visited

Number: 10

Administrative Locations Visited

Number: 1

Total Sample Size

Number: 10
5 - Supported Living
5 - Family Living

Persons Served Interviewed

Number: 10

Persons Served Observed

Number: 10

Records Reviewed (Persons Served)

Number: 10

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

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

QMB Scope and Severity Matrix of survey results

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

			SCOPE		
			Isolated 01% - 15%	Pattern 16% - 79%	Widespread 80% - 100%
SEVERITY	High Impact	Immediate Jeopardy to individual health and or safety	J.	K.	L.
		Actual harm	G.	H.	I.
	Medium Impact	No Actual Harm Potential for more than minimal harm	D.	E.	F. (3 or more)
			D. (2 or less)		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: Transitional Lifestyles Community, Inc. - Metro Region
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living & Family Living)
Monitoring Type: Follow-Up
Dates of Original Survey: June 23 – 26, 2008
Dates of Follow-Up Survey: December 8 -11, 2008

Statute	June 23 - 26, 2008 Deficiencies	December 8 – 11, 2008 Plan of Correction Follow-Up Survey New & Repeat Deficiencies
Tag # 1A08 Agency Case File	Scope and Severity Rating: C	Scope and Severity Rating: NA
<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),</p>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 7 of 12 individuals.</p> <p>Review of the Agency individual case files revealed the following items were missing, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification Information (#3, 7 & 9) • ISP Signature Page (#6) • Addendum A (#1, 6, 9 & 10) • Individual Specific Training (Addendum B) (#6) • Positive Behavioral Plan (#1, 7 & 10) • Speech Therapy Plan (#7 & 9) • Occupational Therapy Plan (#9 & 12) • Physical Therapy Plan (#9 & 12) • Special Health Care Needs <ul style="list-style-type: none"> • Meal Time Plan (#9) 	<p>Complete</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ Individual #3, 6, 7, 9 & 10 - Complete ◦ Individual #12 - No Longer Receiving Services • ISP Signature Page <ul style="list-style-type: none"> ◦ Individual #6 - Complete • Addendum A <ul style="list-style-type: none"> ◦ Individual #1, 6, 9 & 10 - Complete • Individual Specific Training (Addendum B) <ul style="list-style-type: none"> ◦ Individual #6 - Complete • Positive Behavioral Plan <ul style="list-style-type: none"> ◦ Individual #1, 7, & 10 - Complete • Speech Therapy Plan <ul style="list-style-type: none"> ◦ Individual #7 & 9 - Complete • Occupational Therapy Plan <ul style="list-style-type: none"> ◦ Individual #9 - Complete ◦ Individual #12 - No Longer Receiving Services • Physical Therapy Plan <ul style="list-style-type: none"> ◦ Individual #9 - Complete

<p>pharmacy name, address and telephone number, and health plan if appropriate;</p> <p>(2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);</p> <p>(3) Progress notes and other service delivery documentation;</p> <p>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</p> <p>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p>	<ul style="list-style-type: none"> • Annual Physical (#3, 7 & 10) 	<ul style="list-style-type: none"> ◦ Individual #12 - No Longer Receiving Services • Special Health Care Needs <ul style="list-style-type: none"> • Meal Time Plan ◦ Individual #9 - Complete • Annual Physical <ul style="list-style-type: none"> ◦ Individual #3, 7 & 10 - Complete
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Tag # 1A08 Agency Case File - Progress Notes	Scope & Severity Rating: B	Scope and Severity Rating: A
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>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>(3) Progress notes and other service delivery documentation;</p>	<p>Based on record review the Agency failed to maintain progress notes and other service delivery documentation for 4 of 12 Individuals.</p> <p>Current Community Living Progress Notes/Daily Contact Logs</p> <ul style="list-style-type: none"> • Individual #2 - (Not found 5/2008) • Individual #5 - (Not found 12/2007) • Individual #6 - (Not found 5/2008) • Individual #7 - (Not found 5/2007 - 5/2008) 	<p>(New and Repeat Findings) Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 2 of 10 individuals.</p> <p>Current Community Living Progress Notes/Daily Contact Logs</p> <ul style="list-style-type: none"> • # 2, 5 & 7 - Complete. <p>Current Community Living Progress Notes/Daily Current Logs:</p> <ul style="list-style-type: none"> • Individual # 6 (Repeat Finding) - Not found for October 7, 8, 9, 10, 11, 21, 22, 23, 24, 25 & 26, 2008). Per MAD046 the individual receives FL services. • Individual # 8 (New Finding) - Not found for September 28, 29 & 30, 2008). Per MAD046 the individual receives FL services.

Tag # 1A09 Medication Delivery	Scope and Severity Rating: F	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 DDS Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(1) All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals shall be licensed by the Board of Pharmacy, per current regulations.</p> <p>(2) When required by the DDS Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <p>(a) 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;</p> <p>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</p> <p>(c) Initials of the individual administering or</p>	<p>Medication Administration Records (MAR) were reviewed for the months of March, April & May, 2008. The following MARs contained missing medication entries and/or other errors for 10 of 12 individuals.</p> <p>Individual # 1 - No documentation on MAR indicating reason for missing entries.</p> <ul style="list-style-type: none"> • Claritin (10 mg - 1 time daily) - Blank 4/12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30, 2008. • Peridex (.12% Liquid – 2 times daily) - Blank 4/5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30, 2008. • Zyprexa (10 mg - 1 time daily) - Blank 4/9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, & 30, 2008. • Clonazepam (1 mg tablet) - 2 times daily - Blank (AM Dosage) 4/12, 13, 14,15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 &30, 2008 & (PM Dosage) 4/11, 12, 13, 14,15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 &30, 2008 • Tegretol (200 mg - 2 times daily) (AM Dosage) 4/12, 13, 14,15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 &30, 2008 & (PM Dosage) 4/11, 12, 13, 14,15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 &30, 2008 <p>Individual #2</p> <ul style="list-style-type: none"> • March, April & May, 2008 – No MARs were provided to surveyors. <p>Individual #3</p> <ul style="list-style-type: none"> • March, April & May, 2008 – No MARs were provided to surveyors. <p>Individual #6</p>	<p>(New & Repeat Findings) Medication Administration Records were reviewed for the months of August, September & October 2008.</p> <p>Based on record review, 7 of 10 individuals had Medication Administration Records, which contained missing medication entries or other errors:</p> <p>Individual # 1 (Repeat Finding) - No documentation on MAR indicating reason for missing entries.</p> <ul style="list-style-type: none"> • Clonazepam (1mg tablet – 2 times daily) – Blank 8/5/08 • Carbamazepine (200 mg) - P.M. dose – Blank 9/5/08 <p>Individual # 2 (New Finding)</p> <ul style="list-style-type: none"> • Medication Administration Records do not contain the time medication is to be given. MAR notes times as A.M. and P.M. for the following medications: <ul style="list-style-type: none"> • August 2008 <ul style="list-style-type: none"> ◦ Tegretol (10cc a.m. and 11cc p.m. 2 times daily) ◦ Fosamax (20mg liquid – 1 time a week) ◦ Benzamycin (1 pk – 2 times daily) ◦ Gummy Vites Supplement (1 time daily) ◦ Calcium Chews Supplement (500mg – 1 time daily) • September 2008 <ul style="list-style-type: none"> ◦ Tegretol (10cc a.m. and 11cc p.m. 2 times daily) ◦ Fosamax (20mg liquid – 1 time a week) ◦ Benzamycin (1 pk – 2 times daily) ◦ Gummy Vites Supplement (1 time daily)

<p>assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p>	<ul style="list-style-type: none"> • March, April & May, 2008 – No MARs were provided to surveyors. <p>Individual #7 - No documentation on MAR indicating reason for missing entries.</p> <ul style="list-style-type: none"> • March 2008 - No MARs were provided to surveyors. • Lithium Carbonate (300 mg - 1 time daily) - Blank 4/28/2008. • Cod Liver Oil (1 capsule - 2 times daily) - Blank 4/28/2008. • Geodon (60 mg - 2 times daily) - Blank 4/28/2008. • Depakote (250 mg - 3 times daily) - Blank 4/28/2008 (AM dose). <p>Individual #8</p> <ul style="list-style-type: none"> • March, April & May, 2008 – No MARs were provided to surveyors. <p>Individual #9</p> <ul style="list-style-type: none"> • Cyclobenzapine (10mg - 3 times daily) - Blank (3:00 p.m. dose) 3/5, 6, 7, 8, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31, 2008. • Diazepam (2mg - 3 times daily) - Blank (3:00 PM dose) 3/5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31, 2008. • Fosamax (70mg - 1 time weekly) - Blank week of 3/3/2008. <p>Individual #10</p> <ul style="list-style-type: none"> • March, April & May, 2008 – No MARs were provided to surveyors. 	<ul style="list-style-type: none"> ◦ Calcium Chews Supplement (500mg – 1 time daily) <ul style="list-style-type: none"> • October 2008 <ul style="list-style-type: none"> ◦ Tegretol (10cc a.m. and 11cc p.m. 2 times daily) ◦ Fosamax (20mg liquid – 1 time a week) ◦ Benzamycin (1 pk – 2 times daily) ◦ Gummy Vites Supplement (1 time daily) ◦ Calcium Chews Supplement (500mg – 1 time daily) <p>Individual # 3 (New Finding)</p> <ul style="list-style-type: none"> • Medication Administration Records do not contain the time medication is to be given. MAR notes times as A.M. and P.M. for the following medications: <ul style="list-style-type: none"> • August 2008 <ul style="list-style-type: none"> ◦ Centrum Multivitamin (1 tablespoon – Morning) ◦ New Mylanta (2 teaspoonfuls at bedtime) ◦ Loratadine (1 mg – Daily) ◦ Baclofen (20mg – Bed time) ◦ Baclofen (10 mg – 3 times daily) ◦ Clorazepam (1mg – at bedtime) ◦ Prilosec OTC (no dosage listed - bedtime) • September 2008 <ul style="list-style-type: none"> ◦ Centrum Multivitamin (1 tablespoon – Morning) ◦ New Mylanta (2 teaspoonfuls at bedtime) ◦ Loratadine (1 mg – Daily) ◦ Baclofen (20mg – Bed time) ◦ Baclofen (10 mg – 3 times daily) ◦ Clorazepam (1mg – at bedtime) ◦ Prilosec OTC (no dosage listed - bedtime) • October 2008
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	<p>Individual #11 - No documentation on MAR indicating reason for missing entries.</p> <ul style="list-style-type: none"> • Lovastatin (20mg - 1 time daily) – 4/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30, 2008. • Prilosec (20mg - 1 time daily) - Blank 4/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30, 2008. • Thioridazine (25mg - 1 time daily) - Blank 4/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 19 & 30, 2008. • Depakote (500mg - 1 time daily) - Blank 4/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30, 2008. • Lisinopril (20mg - 1 time daily) - Blank 4/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30, 2008. • Oyster Shell (500mg - 1 time daily) - Blank 4/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30, 2008. • Risperdal (2mg - 1 time daily) – Blank 4/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30, 2008. • Reglan (10mg - 2 times daily) – Blank 4/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30, 2008. • Doxazosin Mesylate (1 mg - 1 time daily) - Blank 4/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30, 2008. • Loratadine (10mg - 1 time daily) - Blank 4/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 	<ul style="list-style-type: none"> ◦ Centrum Multivitamin (1 tablespoon – Morning) ◦ New Mylanta (2 teaspoonfuls at bedtime) ◦ Loratadine (1 mg – Daily) ◦ Baclofen (20mg – Bed time) ◦ Baclofen (10 mg – 3 times daily) ◦ Clorazepam (1mg – at bedtime) ◦ Prilosec OTC (no dosage listed - bedtime) <p>Individual # 5 (New Finding) September 2008 No symptoms, effectiveness and nurse’s approval noted for PRN medication:</p> <ul style="list-style-type: none"> • Ibuprofen 600 mg – PRN – September 7, & 23, 2008. <p>October 2008 No symptoms, effectiveness and nurse’s approval noted for PRN medication:</p> <ul style="list-style-type: none"> • Acetaminophen 325 mg – PRN – October 19, & 31, 2008. • Promethazine 25 mg - PRN - October 19, & 31, 2008. <p>Individual # 6 (New Finding)</p> <ul style="list-style-type: none"> • Medication Administration Records do not contain the time medication is to be given. • August 2008 <ul style="list-style-type: none"> ◦ Multivitamin (1 time daily) • September 2008 <ul style="list-style-type: none"> ◦ Multivitamin (1 time daily) • October 2008 <ul style="list-style-type: none"> ◦ Multivitamin (1 time daily) <p>Individual # 7 - Complete</p>
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	<p>30, 2008.</p> <ul style="list-style-type: none"> • Ditropan (5mg -1 time daily) - Blank 4/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30, 2008. • Centrum Silver (1 time daily) - Blank 4/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30, 2008. • Docusate Sodium (100mg - 2 times daily) - Blank 4/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30, 2008. • Peridex (.12% liquid - 2 times daily) - Blank 4/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30, 2008. 	<p>Individual # 8 – Complete</p> <p>Individual # 9 (New Finding) August 2008 Medication Administration Records do not contain the initial and/or name of the staff member assisting with the medications:</p> <ul style="list-style-type: none"> • Hydrocodone/Apap – 7.5/500 – 1 tablet twice daily – August 1, 2008 (am). • Prilosec – 20mg – 1 tablet twice daily– August 14 & 18, 2008 (pm) • Bupropion – 150 mg – 1 tablet twice daily - August 19, 2008 (pm) • Temazepam – 30 mg- 1 capsule at bedtime- August 20, 2008 (pm) <p>September 2008 Medication Administration Records do not contain the initial and/or name of the staff member assisting with the medications:</p> <ul style="list-style-type: none"> • Bupropion – 20 mg – 1 tablet twice daily- September 10, 2008 (pm) <p>Individual # 10 (New Finding) September 2008 Medication Administration Records do not contain the initial and/or signature of the Family Living Provider member assisting with the medications:</p> <ul style="list-style-type: none"> • Propanol –60 mg– 1 tablet daily - September 1 through 30, 2008 • Paxoetine – 20 mg – 1 time a day – September 1 through 30, 2008 • Paxoetine – 30 mg - 1 time daily – September 1 through 30, 2008 • Aricept – 5 mg - 1 at bedtime – September, 1
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		<p>through 30, 2008</p> <ul style="list-style-type: none"> • Oxybutin – 5 mg - 1 at bedtime – September 1 through 30, 2008 <p>October 2008</p> <p>Medication Administration Records do not contain the initial and/or signature of the Family Living Provider member assisting with the medications:</p> <ul style="list-style-type: none"> • Propanol –60 mg– 1 tablet daily - September 1 through 30, 2008 • Paxoetine – 20 mg – 1 time daily – September 1 through 30, 2008 • Paxoetine – 30 mg - 1 time daily – September 1 through 30, 3008 • Aricept – 5 mg - 1 at bedtime – September 1 through 30, 2008 • Oxybutin – 5 mg 1 at bedtime – September 1 through 30, 2008 <p>Individual # 11 – No Longer Receiving Services</p>
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Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: E	Scope and Severity Rating: NA
<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</p>	<p>Based on record review the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 4 of 12 individuals</p> <p>The following were missing or not current:</p> <ul style="list-style-type: none"> • Quarterly Nursing Review if HCP/Crisis Plans <ul style="list-style-type: none"> ◦ None found - 7/2007-9/2007 (#1) ◦ None found - 8/2007-10/2007 & 12/2007-2/2008 (#11) • Healthcare Plans (#11) • Crisis Plans <ul style="list-style-type: none"> ◦ Hypertension (#12) ◦ Behaviors (#12) • Health Assessment Tool (#3) 	<p>Complete</p> <ul style="list-style-type: none"> • Quarterly Nursing Review if HCP/Crisis Plans <ul style="list-style-type: none"> ◦ None found - 7/2007-9/2007 (Individual #1 - Completed) ◦ None found - 8/2007-10/2007 & 12/2007-2/2008 (Individual #11 - No Longer Receiving Services) • Healthcare Plans (#11) <ul style="list-style-type: none"> ◦ Individual #11 - No Longer Receiving Services • Crisis Plans <ul style="list-style-type: none"> • Hypertension (#12) <ul style="list-style-type: none"> ◦ Individual #12 - No Longer Receiving Services • Behaviors (#12) <ul style="list-style-type: none"> ◦ Individual #12 - No Longer Receiving Services • Health Assessment Tool (#3) <ul style="list-style-type: none"> ◦ Individual #3 - Completed

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 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	Scope and Severity Rating: NA
<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 11 of 46 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"> • Basic Health/Orientation (DSP #20 & 27) • Person-Centered Planning (1-Day) (DSP #19, 37 & 40) • First Aid (DSP #23 & 33) • CPR (DSP #23 & 33) • Assisting With Medications (DSP #15 & 19) • Rights & Advocacy (DSP #31) • Level 1 Health (DSP #27 & 31) • Teaching & Support Strategies (DSP #21, 27, 31 & 45) • Positive Behavior Supports Strategies (DSP #27 & 31) 	<p>Complete</p> <ul style="list-style-type: none"> • Basic Health/Orientation <ul style="list-style-type: none"> ◦ DSP # 27 – Complete ◦ DSP # 20 – No Longer Employed • Person-Centered Planning (1-Day) <ul style="list-style-type: none"> ◦ DSP #37 & 40 - Complete ◦ DSP # 19 – No Longer Employed • First Aid <ul style="list-style-type: none"> ◦ DSP #33 - Complete ◦ DSP # 23 – No Longer Employed • CPR <ul style="list-style-type: none"> ◦ DSP #33 – Complete ◦ DSP # 23 – No Longer Employed • Assisting With Medications <ul style="list-style-type: none"> ◦ DSP #15 – Complete ◦ DSP # 19 – No Longer Employed • Rights & Advocacy <ul style="list-style-type: none"> ◦ DSP # 31 – No Longer Employed • Level 1 Health <ul style="list-style-type: none"> ◦ DSP #27 - Complete ◦ DSP # 31 – No Longer Employed • Teaching & Support Strategies <ul style="list-style-type: none"> ◦ DSP #21, 27, & 45 – Complete ◦ DSP # 31 – No Longer Employed • Positive Behavior Supports Strategies <ul style="list-style-type: none"> ◦ DSP #27 - Complete ◦ DSP # 31 – No Longer Employed

Tag # 1A22 Staff Competence	Scope and Severity Rating: F	Scope and Severity Rating: NA
<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> <p>(1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times;</p> <p>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</p> <p>(3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual;</p> <p>(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and</p>	<p>Based on interview, the Agency failed to ensure that training competencies were met for 4 of 6 Direct Service Personnel Interviewed</p> <p>When DSP were asked if they received training on the Individuals ISP, the following was reported:</p> <ul style="list-style-type: none"> • DSP #17 reported they had only learned the goals. • DSP #19 stated, "I was not directed to do so" and reported that they were not trained but read the ISP. • DSP #39 reported they had not been trained but did read ISP. <p>When DSP were asked if they received training on the Individuals Positive Behavioral Supports Plan, the following was reported:</p> <ul style="list-style-type: none"> • DSP #19 stated, "Don't think so." • DSP #39 stated, "I only browsed through Plan." <p>When DSP were asked if they received training on the Individuals Occupational Therapy Plan, the following was reported:</p> <ul style="list-style-type: none"> • DSP #13 stated, "No." • DSP #17 stated, "None." • DSP #19 stated, "No." <p>When DSP were asked if they received training on the Individuals Physical Therapy Plan, the following was reported:</p> <ul style="list-style-type: none"> • DSP #13 stated, "No." • DSP #19 stated, "No." <p>When DSP were asked if they received training on the Individuals Speech Therapy Plan, the following was reported:</p> <ul style="list-style-type: none"> • DSP #19 stated, "No." • DSP #39 stated, "No." 	<p>Complete as stated in Plan of Correction.</p> <ul style="list-style-type: none"> ◦ DSP #13, 17 & 39 – Complete as stated in Plan of Correction ◦ DSP # 19 – No Longer Employed

<p>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 DDS Statewide Training Database as specified in DDS 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 DDS 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 DDS Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p>	<p>When DSP were asked if they received training on the Individuals Health Care Plans, the following was reported:</p> <ul style="list-style-type: none"> • DSP #19 stated, "No." 	
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Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: E	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 20 of 49 Agency Personnel.</p> <ul style="list-style-type: none"> • #14 - Date of Hire 4/07/08 • #15 - Date of Hire 3/11/08 • #18 - Date of Hire 2/08/08 • #19 - Date of Hire 3/12/08 • #31 - Date of Hire 5/17/07 • #32 - Date of Hire 10/11/03 • #34 - Date of Hire 4/21/08 • #35 - Date of Hire 4/14/08 • #40 - Date of Hire 1/14/08 • #42 - Date of Hire 5/30/08 • #43 - Date of Hire 1/25/08 • #45 - Date of Hire 3/09/06 • #46 - Date of Hire 2/06/08 • #47 - Date of Hire 4/14/08 • #48 - Date of Hire 4/07/08 • #49 - Date of Hire 5/21/08 • #50 - Date of Hire 5/09/08 • #51 - Date of Hire 4/18/08 • #52 - Date of Hire 4/14/08 • #53 - Date of Hire 5/17/08 • #59 - Date of Hire 3/02/07 	<p>(Repeat Finding) 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 2 of 28</p> <p>Caregiver Criminal History Screening:</p> <ul style="list-style-type: none"> • #53 & 59 – Not Complete • #15, 34, 40, 42, 45, 50 & 51 - Complete • # 14, 18, 19, 31, 32, 35, 43, 46, 47, 48, 49 & 52 – No Longer Employed

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E	Scope and Severity Rating: NA
<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</p>	<p>Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 13 of 49 Agency Personnel.</p> <ul style="list-style-type: none"> • #14 - Date of Hire 4/07/08 • #16 - Date of Hire 7/05/06 • #17 - Date of Hire 9/15/06 • #27 - Date of Hire 6/15/07 • #28 - Date of Hire 3/02/06 • #29 - Date of Hire 4/28/06 • #31 - Date of Hire 5/17/07 • #33 - Date of Hire 10/9/06 • #35 - Date of Hire 4/14/08 • #37 - Date of Hire 11/30/06 • #42 - Date of Hire 5/30/08 • #45 - Date of Hire 3/09/06 • #53 - Date of Hire 5/17/07 • #54 - Date of Hire 2/23/06 • #55 - Date of Hire 1/24/06 	<p>Complete</p> <ul style="list-style-type: none"> • # 16, 17, 27, 28, 29, 33, 37, 42, 45, 53, 54, & 55 - Complete • # 14, 31, & 35 – No Longer Employed

registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.

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.

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: E	Scope and Severity Rating: NA
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: 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. 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 9 of 49 Agency Personnel.</p> <ul style="list-style-type: none"> • Abuse, Neglect & Exploitation (#15, 23, 25, 38, 41, 44, 45 & 59) <p>When DSP were asked what two State Agencies is suspected Abuse, Neglect and Exploitation reported; the following was reported:</p> <ul style="list-style-type: none"> • DSP #19 stated, "Not sure." 	<p>Complete</p> <ul style="list-style-type: none"> • Abuse, Neglect & Exploitation Training <ul style="list-style-type: none"> ◦ # 15, 25, 44, 45 & 59 - Complete ◦ # 19, 23 & 38 – No Longer Employed

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: E	Scope and Severity Rating: NA
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>E. Consumer and Guardian Orientation Packet: Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.</p>	<p>Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of abuse, neglect or exploitation for 8 of 12 individuals.</p> <ul style="list-style-type: none"> • Parent/Guardian Abuse, Neglect & Exploitation Training (#1, 3, 4, 6, 7, 8, 9 & 12) 	<p>Complete</p> <ul style="list-style-type: none"> • Parent/Guardian Abuse, Neglect & Exploitation Training <ul style="list-style-type: none"> ◦ Individuals # 1, 3, 4, 6, 7, 8 & 9 - Complete ◦ Individual # 12 – No Longer Receiving Services

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: B	Scope and Severity Rating: NA
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: 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. 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 3 of 9 residence</p> <p>Residence of :</p> <ul style="list-style-type: none"> • Individual #4 • Individual # 3 • Individual # 10 	<p>Completed as stated in Plan of Correction</p>

Tag # 1A29 Complaints / Grievances	Scope and Severity Rating: B	Scope and Severity Rating: NA
<p>NMAC 7.26.3.6 A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC].</p> <p>NMAC 7.26.3.13 Client Complaint Procedure Available. A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p>NMAC 7.26.4.13 Complaint Process: A. (2). The service provider's complaint or grievance procedure shall provide, at a minimum, that: (a) the client is notified of the service provider's complaint or grievance procedure</p>	<p>Based on record review, the Agency failed to provide documentation that the complaint procedure had been made available to individuals or their legal guardians for 5 of 12 individuals.</p> <ul style="list-style-type: none"> • Grievance/Complaint Procedure (#3, 4, 6, 7 & 11) 	<p>Complete</p> <ul style="list-style-type: none"> • Grievance/Complaint Procedure <ul style="list-style-type: none"> ◦ Individuals # 3, 4, 6 & 7 - Complete ◦ Individual # 11 – No Longer Receiving Services

Tag # 1A31 (CoP) Client Rights	Scope and Severity Rating: E	Scope and Severity Rating: NA
<p>NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]</p>	<p>Based on record review, the Agency failed to ensure the rights of Individuals were not restricted or limited for 5 of 12 Individuals.</p> <p>A review of the Agency Individual files found no documentation of Positive Behavior Plans being reviewed at least quarterly. (#1, 4, 7, 10 & 11)</p> <p>A review of Agency Individual files found no documentation indicating Positive Behavior Plans were approved by the Human Rights Committee. (#1, 4, 7, 10 & 11)</p>	<p>Complete</p> <ul style="list-style-type: none"> ◦ Individuals # 1, 4, 7 & 10 - Complete ◦ Individual # 11 – No longer Receiving Services

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: E	Scope and Severity Rating: D
<p>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities.</p>	<p>Based on record review the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 3 of 12 individuals.</p> <p>Per Individuals ISP's the following was found with regards to the implementation of ISP Outcomes:</p> <p>Community Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <ul style="list-style-type: none"> • None found for 04/2008 (Individual #1) • None found for 12/2007 (Individual #5) • None found for 03/2008 – 05/2008 (Individual #12) 	<p>(New Finding) Based on record review the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 10 individuals.</p> <p>Community Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <ul style="list-style-type: none"> • Individuals #1 & 5 – Complete • Individual #12 – No Longer Receiving Services • (New Finding) Individual # 7 - None found for 3/2008 & 4/2008

Tag # 1A33 Board of Pharmacy - Med Storage:	Scope and Severity Rating: B	Scope and Severity Rating: NA
<p>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual</p> <p>6. Display of License and Inspection Reports</p> <p>A. The following are required to be publicly displayed:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Current Custodial Drug Permit from the NM Board of Pharmacy <input type="checkbox"/> Current registration from the consultant pharmacist <input type="checkbox"/> Current NM Board of Pharmacy Inspection Report 	<p>Based on observation and interview the Agency failed to provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 4 of 7 residence:</p> <p>Individual Residence:</p> <ul style="list-style-type: none"> • Current Registration of Consulting Pharmacist (#4) • Current NM Board of Pharmacy Inspection report (#5) 	<p>Complete</p> <p>Individual Residence:</p> <ul style="list-style-type: none"> • Current Registration of Consulting Pharmacist <ul style="list-style-type: none"> ◦ Individual #4 - Completed • Current NM Board of Pharmacy Inspection report <ul style="list-style-type: none"> ◦ Individual #5 - Completed

Tag # 1A36 SC Training	Scope and Severity Rating: B	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(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>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 3 Service Coordinators.</p> <p>Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:</p> <ul style="list-style-type: none"> • Promoting Effective Teamwork (SC #60) 	<p>Complete</p> <ul style="list-style-type: none"> • Promoting Effective Teamwork <ul style="list-style-type: none"> ◦ Service Coordinator #60 – No Longer Employed

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: E	Scope and Severity Rating: NA
<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 8 of 49 Agency Personnel.</p> <ul style="list-style-type: none"> • Individual Specific Training (#14, 21, 35, 49, 51, 55, 59 & 60) 	<p>Complete</p> <p>Individual Specific Training</p> <ul style="list-style-type: none"> • # 21, 51, 55, 59 – Complete • # 14, 35, 49 & 60 - No Longer Employed

Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: F	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 5 of 5 individuals.</p> <ul style="list-style-type: none"> • DDSD Approval for Subcontractor (#3 & 10) • Family Living (Initial) Home Study (#3) • Family Living (Annual Update) Home Study (#3) • Current Family Living Contract (# 2, 3, 6, & 8) 	<p>(New and Repeat Finding) Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 5 of 5 individuals.</p> <ul style="list-style-type: none"> • (New Finding) DDSD Approval for Subcontractor (#2, 6 & 8) • (Repeat Finding) DDSD Approval for Subcontractor (#3 & 10) • Family Living (Initial) Home Study <ul style="list-style-type: none"> ◦ Individual #3 – Complete • Family Living (Annual Update) Home Study – Complete <ul style="list-style-type: none"> ◦ Individual #3 – Complete • Current Family Living Contract <ul style="list-style-type: none"> ◦ Individual (# 2, 3, 6, & 8 – Complete

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: F	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</p> <p>G. Health Care Requirements for Community Living Services.</p> <p>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first.</p> <p>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <p>(a) Provision of health care oversight consistent with these Standards as detailed</p>	<p>Based on record review, the Agency failed to provide documentation of Health Care Requirements for 10 of 12 individuals.</p> <p>Health Assessment Tool</p> <ul style="list-style-type: none"> • Individual #3, 5, 10 & 12 <p>Health Care Plans</p> <ul style="list-style-type: none"> • Individual #3, 7, 10 & 11 <p>Crisis Prevention/Intervention Plans (#1, 4, 7 & 12)</p> <ul style="list-style-type: none"> • Seizures (Individual #1) • Behavior (Individual #4, 7 & 12) • Hypertension (Individual #12) <p>Other documents:</p> <ul style="list-style-type: none"> • Auditory Exam (# 4, 6, 7 & 10) • Vision Exam (# 4, 6, & 8) 	<p>Complete</p> <p>Health Assessment Tool</p> <ul style="list-style-type: none"> • Individual #3, 5 & 10 - Completed • Individual #12 - No Longer Receiving Services <p>Health Care Plans</p> <ul style="list-style-type: none"> • Individual #3, 7 & 10 - Completed • Individual #11 - No Longer Receiving Services <p>Crisis Prevention/Intervention Plans</p> <ul style="list-style-type: none"> • Seizures (Individual #1) Completed • Behavior <ul style="list-style-type: none"> ◦ Individual #4 & 7 - Completed ◦ Individual #12 - No Longer Receiving Services • Hypertension (Individual #12 - No Longer Receiving Services) <p>Other documents:</p> <ul style="list-style-type: none"> • Auditory Exam (# 4, 6, 7 & 10 - Completed) • Vision Exam (# 4, 6 & 8 - Completed)

<p>in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>(b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.</p> <p>(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <p>(a) The individual has a primary licensed physician;</p> <p>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</p> <p>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</p> <p>(d) The individual receives eye examinations as specified by a licensed optometrist or</p>		
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<p>ophthalmologist; and</p> <p>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</p>		
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Tag # 6L14 Residential Case File	Scope and Severity Rating: F	Scope and Severity Rating: D
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>A. Residence Case File: For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:</p> <p>(1) Complete and current ISP and all supplemental plans specific to the individual;</p> <p>(2) Complete and current Health Assessment Tool;</p> <p>(3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;</p> <p>(4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);</p> <p>(5) Data collected to document ISP Action Plan implementation</p> <p>(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 12 of 12 Individuals receiving Family Living Services or Supported Living Services.</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification (#3, 7 & 10) • Annual ISP (#1, 4, 5, 7 & 10) • ISP Signature Page (#3, 5, 7, 10 & 12) • Addendum A (#1, 3, 4, 5, 7, 9, 10, 11 & 12) • Individual Specific Training (Addendum B) (#3, 5, 7, 9 & 10) • Positive Behavioral Plan (#3, 4 & 10) • Speech Therapy Plan (#1, 3, 6, 7, 9 & 11) • Occupational Therapy Plan (#3, 7, 8, 9 & 12) • Physical Therapy Plan (#2, 3, 7, 9 & 10) • Special Health Care Needs <ul style="list-style-type: none"> • Nutritional Plan (#1, 3 & 8) • Meal Time Plan (#9) • Health Assessment Tool (#3, 5, 10 & 12) • Health Care Plans (#3, 7, 10 & 11) • Crisis Plan <ul style="list-style-type: none"> • Seizures (#1) • Behaviors (#4 & 7) • Hypertension (#12) • Progress Notes/Daily Contacts Logs (#1, 3, 4, 5, 6, 7, 9, 10, 11 & 12) 	<p>(New Finding) Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 1 of 10 Individuals receiving Family Living Services or Supported Living Services.</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification <ul style="list-style-type: none"> ◦ Individual #3, 7 & 10 - Complete • Annual ISP <ul style="list-style-type: none"> ◦ Individual #1, 4, 5, 7 & 10 - Complete • ISP Signature Page (#3, 5, 7, & 10 - Complete) <ul style="list-style-type: none"> ◦ Individual #12 - No Longer receiving Services • Addendum A <ul style="list-style-type: none"> ◦ Individuals #1, 3, 4, 5, 7, 9, & 10 - Complete ◦ Individuals #11 & 12 - No Longer Receiving Services • Individual Specific Training (Addendum B) <ul style="list-style-type: none"> ◦ Individual #3, 5, 7, 9 & 10 - Complete • Positive Behavioral Plan <ul style="list-style-type: none"> ◦ Individual #3, 4 & 10 - Complete • Speech Therapy Plan <ul style="list-style-type: none"> ◦ Individual #1, 3, 6, 7 & 9 – Complete ◦ Individual #11- No Longer receiving Services • Occupational Therapy Plan <ul style="list-style-type: none"> ◦ Individual #3, 7, 8 & 9 – Complete ◦ Individual #12 – No Longer Receiving Services • Physical Therapy Plan <ul style="list-style-type: none"> ◦ Individual #2, 3, 7, 9 & 10 - Complete • Special Health Care Needs <ul style="list-style-type: none"> • Nutritional Plan <ul style="list-style-type: none"> ◦ Individual #1, 3 & 8 - Complete

<p>response to identified changes in condition for at least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of 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> <p>(a) The name of the individual;</p> <p>(b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;</p> <p>(c) Diagnosis for which the medication is prescribed;</p> <p>(d) Dosage, frequency and method/route of delivery;</p> <p>(e) Times and dates of delivery;</p> <p>(f) Initials of person administering or assisting with medication; and</p> <p>(g) An explanation of any medication irregularity, allergic reaction or adverse effect.</p> <p>(h) For PRN medication an explanation for the use of the PRN must include:</p> <p>(i) Observable signs/symptoms or circumstances in which the medication is to be used, and</p> <p>(ii) Documentation of the effectiveness/result of the PRN delivered.</p> <p>(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> <p>(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year</p>	<ul style="list-style-type: none"> • Data Collection/Data Tracking (#1, 3, 4, 5, 6, 7, 8, 9, 10, 11 & 12) • Progress Notes written by DSP and/or Nurses (#2, 3, 4, 5, 6, 8 & 10) • Health Care Providers Written Orders (#3, 4, 5, 6 & 12) • Record of visits of healthcare practitioners (#2, 3, 4, 7, 8 & 10) • Medication Administration Record (MAR): <ul style="list-style-type: none"> ◦ None found for March, April & May, 2008 (#2, 3, 6, 8, & 10) ◦ None found for March 2008 (#7) ◦ None found for May 2008) (#11) 	<ul style="list-style-type: none"> • Meal Time Plan <ul style="list-style-type: none"> ◦ Individual #9 - Complete • Health Assessment Tool <ul style="list-style-type: none"> ◦ Individual #3, 5 & 10 – Complete ◦ Individual # 12 – No Longer receiving Services • Health Care Plans <ul style="list-style-type: none"> ◦ Individual #3, 7 & 10 – Complete ◦ Individual # 11 – No Longer Receiving Services • Crisis Plan <ul style="list-style-type: none"> • Seizures <ul style="list-style-type: none"> ◦ Individual #1 - Complete • Behaviors <ul style="list-style-type: none"> ◦ Individual #4 & 7 - Complete • Hypertension <ul style="list-style-type: none"> ◦ Individual #12 - No Longer Receiving Services • Progress Notes/Daily Contacts Logs <ul style="list-style-type: none"> ◦ Individuals #1, 3, 4, 5, 6, 7, 9 & 10 – Complete ◦ Individuals # 11 & 12 – No Longer Receiving Services • Data Collection/Data Tracking <ul style="list-style-type: none"> ◦ Individuals #1, 3, 4, 5, 6, 8, 9 & 10 – Complete ◦ Individual #7 - None found for 3/2008 & 4/2008. ◦ Individuals #11 & 12 – No Longer Receiving Services • Progress Notes written by DSP and/or Nurses <ul style="list-style-type: none"> ◦ Individuals #2, 3, 4, 5, 6, 8 & 10 - Complete • Health Care Providers Written Orders <ul style="list-style-type: none"> ◦ Individuals #3, 4, 5 & 6 – Complete ◦ Individual # 12 – No Longer receiving Services • Record of visits of healthcare practitioners
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- Individuals #2, 3, 4, 7, 8 & 10 - Complete
- Medication Administration Record (MAR):
 - Individuals # 2, 3, 6, & 10 – Complete for August, September, October, 2008
 - Individual #11 – No Longer Receiving Services

Tag # 6L17 Reporting Requirements	Scope and Severity Rating: A	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>D. Community Living Service Provider Agency Reporting Requirements: All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation:</p> <ol style="list-style-type: none"> (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members. 	<p>Based on Record Review the Agency failed to complete written quarterly status reports for 2 of 12 individuals receiving Community Living Services.</p> <p>Community Living Quarterly Reports:</p> <ul style="list-style-type: none"> • Individual # 7- None found from May 2007 through May 2008 • Individual # 11 - None found from May 2007 through May 2008 	<p>Complete</p> <p>Individual #7 - Complete</p> <p>Individual #11 – No Longer Receiving Services</p>

Tag # 6L25 (CoP) Residential Reqts.	Scope and Severity Rating: F	Scope and Severity Rating: A
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>L. Residence Requirements for Family Living Services and Supported Living Services</p> <p>(1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has:</p> <p>(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;</p> <p>(b) General-purpose first aid kit;</p> <p>(c) When applicable due to an individual's health status, a blood borne pathogens kit;</p> <p>(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;</p> <p>(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;</p> <p>(f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;</p> <p>(g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and</p> <p>(h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.</p>	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 8 of 8 Supported Living and Family Living residences.</p> <p>The following items were missing, not functioning or incomplete:</p> <ul style="list-style-type: none"> • Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence (#1, 3, 4, 9, 10, 11 & 12) • General-purpose first aid kit (#3 & 10) • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#2, 3, 10 & 12) • Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#6 & 7) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#1, 2, 5, 6, 9, 11 & 12) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 2, 3, 5, 6, 7, 8, 9, 10, 11 & 12) 	<p>(Repeat Finding) Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 2 of 10 Supported Living and Family Living residences.</p> <p>The following items were missing, not functioning or incomplete:</p> <ul style="list-style-type: none"> • Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence for Individuals. <ul style="list-style-type: none"> ◦ Individual #1, 3, 4, 9 & 10 - Complete ◦ Individual # 11 & 12 - No Longer Receiving Services • General-purpose first aid kit <ul style="list-style-type: none"> ◦ Individual #3 & 10 - Complete • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats <ul style="list-style-type: none"> ◦ Individual #2, 3 & 10 – Complete ◦ Individual #12 – No Longer Receiving Services • Accessible telephone numbers of poison control centers located within the line of sight of the telephone <ul style="list-style-type: none"> ◦ Individual #6 & 7 - Complete • 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 <ul style="list-style-type: none"> ◦ Individual #1, 2, 5, 6 & 9 - Complete ◦ Individual # 11 & 12 – No Longer Receiving Services • 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.

- Individual #1, 2, 3, 7, 8 & 10 - Complete
- Individual #5 & 6 – **Not Complete**
- Individuals #11 & 12 – No Longer Receiving Services

Tag # 6L27 FL Reimbursement	Scope and Severity Rating: A	Scope and Severity Rating: NA
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES</p> <p>B. Reimbursement for Family Living Services</p> <p>(1) Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year.</p> <p>(2) Billable Activities shall include:</p> <p>(a) Direct support provided to an individual in the residence any portion of the day;</p> <p>(b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and</p> <p>(c) Any other activities provided in accordance with the Scope of Services.</p> <p>(3) Non-Billable Activities shall include:</p> <p>(a) The Family Living Services Provider Agency may not bill the for room and board;</p> <p>(b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and</p> <p>(c) Family Living services may not be billed for the same time period as Respite.</p> <p>(d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one midnight to the following midnight.</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 1 of 5 individuals.</p> <p>Individual # 3</p> <ul style="list-style-type: none"> • March 2008 Agency billed 31 units of Family Living. Documentation received accounted for 21 units. • April 2008 Agency billed 30 units of Family Living. Documentation received accounted for 22 units. • May 2008 Agency billed 31 units of Family Living. Documentation received accounted for 21 units. 	<p>Complete</p>