

Date: May 11, 2020

To: Johnathan Baca, Executive Director
Provider: Bright Horizons, Inc.
Address: 3809 Academy Parkway S. NE
City, State/Zip: Albuquerque, New Mexico 87109

E-mail Address: jonb@brighthousenm.com

Board Chair E-Mail Address: kimberlyallenm@gmail.com

Region: Metro
Routine Survey: September 13 – 19, 2019
Verification Survey: April 6, 2020 – 17, 2020

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2018:** Supported Living, Family Living; Customized In-Home Supports; Customized Community Supports, and Community Integrated Employment Services

Survey Type: Verification

Team Leader: Elisa C. Perez Alford, MSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Bernadette Baca, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Kayla Benally BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Wolf Krusemark, BFA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Johnathan Baca;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on September 13 – 19, 2019*.

The Division of Health Improvement, Quality Management Bureau has determined your agency is now in: **Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags:** This determination is based on noncompliance with one to five (1 – 5) Condition of Participation Level Tags (*refer to Attachment D for details*). The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # 1A09.1 Medication Delivery PRN Medication Administration (**New / Repeat Findings**)

The following tags are identified as Standard Level:

DIVISION OF HEALTH IMPROVEMENT

5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108
(505) 222-8623 • FAX: (505) 222-8661 • <https://nmhealth.org/about/dhi/>

QMB Report of Findings – Bright Horizons, Inc. – Metro – April 6 – 17, 2020

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- Tag # 1A09 Medication Delivery Routine Medication Administration (**New / Repeat Findings**)
- Tag # 1A09.0 Medication Delivery Routine Medication Administration (**New / Repeat Findings**)
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans) (**Repeat Findings**)

However, due to the new/repeat deficiencies your agency will be referred to the Internal Review Committee (IRC). Your agency will also be required to contact your DDS Regional Office for technical assistance and follow up and complete the Plan of Correction document attached at the end of this report. Please respond to the Plan of Correction Coordinator within 10 business days of receipt of this letter.

Plan of Correction:

The attached Report of Findings identifies the new/repeat Standard Level deficiencies found during your agency’s verification compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 10 business days from the receipt of this letter. The Plan of Correction must include the following:

1. Evidence your agency has contacted your DDS Regional Office for technical assistance;
2. A Plan of Correction detailing Quality Assurance/Quality Improvement processes to prevent your agency from receiving deficiencies in the future. Please use the format provided at the end of this report;
3. Documentation verifying that newly cited deficiencies have been corrected.

Submission of your Plan of Correction:

Please submit your agency’s Plan of Correction and documentation verifying correction of survey deficiencies within 10 business days of receipt of this letter to the parties below:

1. **Quality Management Bureau, Attention: Plan of Correction Coordinator**
5301 Central Ave. NE Suite 400, New Mexico 87108
MonicaE.Valdez@state.nm.us
2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

Failure to submit your POC within the allotted 10 business days may result in the imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Please contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@state.nm.us if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Elisa C. Perez Alford, MSW

Elisa C. Perez Alford, MSW
 Team Lead/Healthcare Surveyor
 Division of Health Improvement
 Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	April 6, 2020
Contact:	<u>Bright Horizons, Inc.</u> Jonathan Baca, Executive Director Rebecca Scannell, Quality Assurance Manager <u>DOH/DHI/QMB</u> Elisa C. Perez Alford, MSW, Team Lead/Healthcare Surveyor
Desk Audit Entrance Conference Date:	April 6, 2020
Present:	<u>Bright Horizons, Inc.</u> Jonathan Baca, Executive Director <u>DOH/DHI/QMB</u> Elisa C. Perez Alford, MSW, Team Lead/Healthcare Surveyor
Exit Conference Date:	April 17, 2020
Present:	<u>Bright Horizons, Inc.</u> Jonathan Baca, Executive Director Rebecca Scannell, Quality Assurance Manager Ian Collyer, Licensed Practical Nurse <u>DOH/DHI/QMB</u> Elisa C. Perez Alford, MSW, Team Lead/Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor <u>DDSD - Metro Regional Office</u> Fleur Dahl, Social Services Community Coordinator
Administrative Locations Visited:	0 (Note: No administrative locations visited due to COVID- 19 Public Health Emergency)
Total Sample Size:	13 1 - Jackson Class Member 12 - Non-Jackson Class Members 9 - Supported Living 3 - Family Living 1 - Customized In-Home Supports 10 - Customized Community Supports 1 - Community Integrated Employment
Persons Served Records Reviewed	13
Direct Support Personnel Interviewed during Routine Survey	16
Direct Support Personnel Records Reviewed	110
Substitute Care/Respite Personnel Records Reviewed	10

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Service Coordinator Records Reviewed	5
Nurse Interviews completed during Routine Survey	1
Nurse Interview completed during Verification Survey	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
 - Individual Service Plans
 - Progress on Identified Outcomes
 - Healthcare Plans
 - Medication Administration Records
 - Medical Emergency Response Plans
 - Therapy Evaluations and Plans
 - Healthcare Documentation Regarding Appointments and Required Follow-Up
 - Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- Evacuation Drills of Residences and Service Locations
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement
 DOH - Developmental Disabilities Supports Division
 DOH - Office of Internal Audit
 HSD - Medical Assistance Division
 NM Attorney General's Office

Attachment B

Department of Health, Division of Health Improvement QMB Determination of Compliance Process

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and other state and federal regulations. For the purpose of the LCA / CI survey the CMS waiver assurances have been grouped into four (4) Service Domains: Plan of Care (ISP Implementation); Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Assurance system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

Each deficiency in your Report of Findings has been predetermined to be a Standard Level Deficiency, a Condition of Participation Level Deficiency, if below 85% compliance or a non-negotiable Condition of Participation Level Deficiency. Your Agency's overall Compliance Determination is based on a Scope and Severity Scale which takes into account the number of Standard and Condition Level Tags cited as well as the percentage of Individuals affected in the sample.

Conditions of Participation (CoPs)

CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances, in addition to the New Mexico Developmental Disability Waiver (DDW) Service Standards. The Division of Health Improvement (DHI), in conjunction with the Developmental Disability Support Division (DDSD), has identified certain deficiencies that have the potential to be a Condition of Participation Level, if the tag falls below 85% compliance based on the number of people affected. Additionally, there are what are called non-negotiable Conditions of Participation, regardless if one person or multiple people are affected. In this context, a CoP is defined as an essential / fundamental regulation or standard, which when out of compliance directly affects the health and welfare of the Individuals served. If no deficiencies within a Tag are at the level of a CoP, it is cited as a Standard Level Deficiency.

Service Domains and CoPs for Living Care Arrangements and Community Inclusion are as follows:

Service Domain: Service Plan: ISP Implementation - *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A08.3** – Administrative Case File: Individual Service Plan / ISP Components
- **1A32** – Administrative Case File: Individual Service Plan Implementation
- **LS14** – Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- **IS14** – CCS / CIES Service Delivery Site Case File (ISP and Healthcare Requirements)

Service Domain: Qualified Providers - *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A20** - Direct Support Personnel Training

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- **1A22** - Agency Personnel Competency
- **1A37** – Individual Specific Training

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):

- **1A25.1** – Caregiver Criminal History Screening
- **1A26.1** – Consolidated On-line Registry Employee Abuse Registry

Service Domain: Health, Welfare and Safety - *The State, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A08.2** – Administrative Case File: Healthcare Requirements & Follow-up
- **1A09** – Medication Delivery Routine Medication Administration
- **1A09.1** – Medication Delivery PRN Medication Administration
- **1A15.2** – Administrative Case File: Healthcare Documentation (Therap and Required Plans)

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):

- **1A05** – General Requirements / Agency Policy and Procedure Requirements
- **1A07** – Social Security Income (SSI) Payments
- **1A09.2** – Medication Delivery Nurse Approval for PRN Medication
- **1A15** – Healthcare Coordination - Nurse Availability / Knowledge
- **1A31** – Client Rights/Human Rights
- **LS25.1** – Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

Attachment C

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

Introduction:

Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated "Document Request," or "Administrative Needs," etc. forms. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Bureau Chief **within 10 business days** of receipt of the final Report of Findings (**Note: No extensions are granted for the IRF**).
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: <https://nmhealth.org/about/dhi/cbp/irf/>
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRF process, email the IRF Chairperson, Valerie V. Valdez at valerie.valdez@state.nm.us for assistance.

The following limitations apply to the IRF process:

- The written request for an IRF and all supporting evidence must be received within 10 business days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed or requested by the survey team.
- Providers must continue to complete their Plan of Correction during the IRF process
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition.
- Providers may not request an IRF to challenge the DHI/QMB determination of compliance or the length of their DDSD provider contract.

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

The IRF Committee will review the request; the Provider will be notified in writing of the ruling; no face-to-face meeting will be conducted.

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

QMB Determinations of Compliance

Compliance:

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or that no deficiencies at the Condition of Participation Level were found. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of *Compliance*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

Partial-Compliance with Standard Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags* indicates that a provider is in compliance with all Condition of Participation Level deficiencies but is out of compliance with a certain percentage of Standard Level deficiencies. This partial compliance, if not corrected, may result in a negative outcome or the potential for more than minimal harm to individuals' health and safety. There are two ways to receive a determination of Partial Compliance with Standard Level Tags:

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.
2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags. This partial compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety.

Non-Compliance:

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. There are three ways an agency can receive a determination of Non-Compliance:

1. Your Report of Findings includes 17 or more total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level tag.
2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

Compliance Determination	Weighting						
	LOW		MEDIUM			HIGH	
Total Tags:	up to 16	17 or more	up to 16	17 or more	Any Amount	17 or more	Any Amount
	and	and	and	and	And/or	and	And/or
COP Level Tags:	0 COP	0 COP	0 COP	0 COP	1 to 5 COP	0 to 5 CoPs	6 or more COP
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
"Non-Compliance"						17 or more Total Tags with 75 to 100% of the Individuals in the sample cited in any CoP Level tag.	Any Amount of Standard Level Tags and 6 or more Conditions of Participation Level Tags.
"Partial Compliance with Standard Level tags and Condition of Participation Level Tags"					Any Amount Standard Level Tags, plus 1 to 5 Conditions of Participation Level tags.		
"Partial Compliance with Standard Level tags"			up to 16 Standard Level Tags with 75 to 100% of the individuals in the sample cited in any tag.	17 or more Standard Level Tags with 50 to 74% of the individuals in the sample cited any tag.			
"Compliance"	Up to 16 Standard Level Tags with 0 to 74% of the individuals in the sample cited in any tag.	17 or more Standard Level Tags with 0 to 49% of the individuals in the sample cited in any tag.					

Agency: Bright Horizons, Inc. – Metro
Program: Developmental Disabilities Waiver
Service: 2018: Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports, and Community Integrated Employment Services
Survey Type: Verification
Routine Survey: September 13 - 19, 2019
Verification Survey: April 6 – 17, 2020

Standard of Care	Routine Survey Deficiencies September 13 - 19, 2019	Verification Survey New and Repeat Deficiencies April 6 –17, 2020
<i>Service Domain: Health and Welfare - The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.</i>		
Tag # 1A09 Medication Delivery Routine Medication Administration	Condition of Participation Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR): A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for:</p> <ol style="list-style-type: none"> 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 2. Including the following on the MAR: 	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Medication Administration Records (MAR) were reviewed for the months of August and September 2019.</p> <p>Based on record review, 7 of 13 individuals had Medication Administration Records (MAR), which contained missing medication entries and/or other errors:</p> <p>Individual #5 August 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Amlodipine Besylate 10mg (1 time daily) – Blank 8/27 – 29. • Aripiprazole 2mg (1 time daily) – Blank 8/27, 28. 	<p>New/Repeat Finding:</p> <p>Medication Administration Records (MAR) were reviewed for the month March 2020.</p> <p>Based on record review, 1 of 11 individuals had Medication Administration Records (MAR), which contained missing medication entries and/or other errors:</p> <p>Individual #5 March 2020 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Nitrofurantoin Cap 100 mg (2 times daily with a meal for 5 days) – Blank 3/7, 9. • Nystatin POW 100,000 (1 time daily) – Blank 3/1 – 31 (8:00 PM).

<ol style="list-style-type: none"> 1. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; 2. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; 3. Documentation of all time limited or discontinued medications or treatments; 4. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; 5. Documentation of refused, missed, or held medications or treatments; 6. Documentation of any allergic reaction that occurred due to medication or treatments; and 7. For PRN medications or treatments: <ol style="list-style-type: none"> 1. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; 2. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and 	<ul style="list-style-type: none"> • Carvedilol 12.5mg tablets (2 times daily) – Blank: 8/27, 28, 29 (8:00AM) and 8/27, 28 (8:00PM). • Docusate Sodium (1 time daily) – Blank 8/28. • Fluticasone 50mcg (1 time daily) – Blank 8/14 – 16, 26 – 28. • Loratadine 10mg (1 time daily) – Blank 8/27 – 29. • Losartan Potassium 25mg (1 time daily) – Blank 8/27 – 29 (Time AM or PM). • Magnesium Oxide 400mg (1 time daily) – Blank 8/26 – 8/28 (Time AM or PM). • Multivitamin (1 time daily) – Blank 8/23, 28,-29 (Time AM or PM). • Mycophenolic 180mg (3 times daily) – Blank 8/27 – 29, (8:00AM) 8/27, 28 (8:00PM) • Nortrel 1-35 (1 time daily) – Blank 8/27 – 29 (8:00 AM). • Sertraline HCL 50mg (1 time daily) – Blank 8/27 – 29. • Sirolimus 0.5mg (1 time daily) – Blank 8/22 – 29. • Thera Tears .25% Eye Drops (2 times daily) – Blank 8/26 – 29 (8:00AM) and 8/25, 28 (8:00PM) <p>September 2019 Medication Administration Records contained missing entries. No documentation found</p>	
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<p>3. documentation of the effectiveness of the PRN medication or treatment.</p> <p>Chapter 10 Living Care Arrangements 10.3.4 Medication Assessment and Delivery: Living Supports Provider Agencies must support and comply with:</p> <p>8. the processes identified in the DDS AWMD training;</p> <p>9. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services;</p> <p>10. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and</p> <p>11. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. 	<p>indicating reason for missing entries (<i>Date of home visit:9/18/2019</i>):</p> <ul style="list-style-type: none"> • Ciprofloxacin Sol .2% (2 times daily) – Blank 9/1 – 2 (8:00AM & 8:00PM) and 9/3 (8AM). • Nystatin topical powder (1 time daily) – Blank 9/1 – 9 (8 PM). <p>Individual #6 August 2019 Medication Administration Records did not contain the correct diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Valproic Acid 250 mg (2 times daily). <i>Note: MAR indicated medication was to be given for seizures. Physician orders indicated medication was to be given as a mood stabilizer.</i> <p>September 2019 Medication Administration Records did not contain the correct diagnosis for which the medication is prescribed (<i>Date of home visit: 9/16/2019</i>):</p> <ul style="list-style-type: none"> • Valproic Acid 250 mg (2 times daily). <i>Note: MAR indicated medication was to be given for seizures. Physician orders indicated medication was to be given as a mood stabilizer.</i> <p>Individual #11 August 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Adrenal Boost (1 time daily) – Blank 8/1 – 31. • B-Complex (1 time daily) – Blank 8/1 – 31 (8 AM) 	
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<p>Model Custodial Procedure Manual D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ol style="list-style-type: none"> 1. symptoms that indicate the use of the medication, 2. exact dosage to be used, and 3. the exact amount to be used in a 24-hour period. 	<ul style="list-style-type: none"> • Cetirizine 10mg (1 time daily) – Blank 8/1 – 31 (8 PM) • Chlorhexidine Gluc 0.12% SOL (2 times daily) – Blank 8/1 – 31 • Estroven (1 time daily) – Blank 8/1 – 31. • Fish oil 1000mg (1 time daily) – Blank 8/1 – 31 (8 AM). • Fluticasone 50mcg (1 time daily) – Blank 8/1 – 31 (8 AM). • GM BIES 2.5mg TPG 1 pump every am (1 time daily) – Blank 8/1 - 31 (AM). • GM BIES 2.5mg TPG 2 pumps every pm (1 time daily) – Blank 8/1 - 31 (PM). • Multi-vitamin (1 time daily) – Blank 8/1 – 31 (8AM). • Nite Vites 3 tabs (1 time daily) – Blank 8/1 - 31. • Polyethylene Glyc Pow 3350 NF (1 time daily) – Blank 8/1 - 31 (8AM). • Thyroid Boost (1 times daily) – Blank 8/1 – 31. • Vitamin B12 100mcg (1 time daily) – Blank 8/1 - 31. • Vitamin C 1000mg (1 time daily) – Blank 8/1 - 31. • Vitamin D3 2000-unit (1 time daily) – Blank 8/1 – 31 (8AM). 	
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September 2019

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries (*Date of home visit: 9/17/2019*):

- Adrenal Boost (1 time daily) – Blank 9/1 – 17.
- B-Complex (1 time daily) – Blank 9/1 – 17 (8 AM).
- Cetirizine 10mg (1 time daily) – Blank 9/1 – 17 (8 PM).
- Chlorhexidine Gluc 0.12% SOL (2 times daily) – Blank 9/1 – 17 (8:00 AM & 8:00PM).
- Estroven (1 time daily) – Blank 9/1 – 17.
- Fish oil 1000mg (1 time daily) – Blank 9/1 – 17 (8 AM).
- Fluticasone 50mcg SPR (1 time daily) – Blank 9/1 – 17 (8 AM).
- Multi-vitamin (1 time daily) – Blank 9/1 – 17 (8 AM).
- Nite Vites (1 time daily) – Blank 9/1 – 17.
- Polyethylene Glyc Pow 3350 NF (1 time daily) – Blank 9/1 – 17 (8 AM).
- Thyroid Boost (1 time daily) – Blank 9/1 – 17.
- Vitamin B12 100mcg (1 time daily) – Blank 9/1 – 17.
- Vitamin C 1000mg (1 time daily) – Blank 9/1 – 17.

	<ul style="list-style-type: none"> • Vitamin D3 2000-unit (1 time daily) – Blank 9/1 – 17 (8 AM). <p>September 2019 Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:</p> <ul style="list-style-type: none"> • Adrena Sense (1 – 2 times daily) • Adrenal Boost (1 time daily) • Estoven (1 time daily) • Nite Vites (1 time daily) • Thyroid Boost (1 times daily) • Vitamin B12 100mg (1 time daily) • Vitamin C 500mg (1 time daily) <p>Individual #12 August 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Chlorhexidine Gluc 0.12% (2 times daily) – Blank 8/1 – 31 (8:00 AM). <p>September 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries (<i>Date of home visit: 9/16/2019</i>):</p> <ul style="list-style-type: none"> • Chlorhexidine Gluc 0.12% (2 times daily) – Blank 9/1 – 16 (AM and PM). <p>Individual #13 September 2019</p>	
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	<p>Medication Administration Records indicated the following medication were to be given. The following Medications were not found in the home:</p> <ul style="list-style-type: none">• Deep Sea 0.65% spray (3 times daily) <p>Individual #16 September 2019</p> <p>Medication Administration Records indicated the following medication were to be given. The following Medications were not found in the home (<i>Date of home visit: 9/16/2019</i>):</p> <ul style="list-style-type: none">• Ketocenazole Cream 2% (1 time daily)• Minerin Cream (3 times weekly)	
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Tag # 1A09.0 Medication Delivery Routine Medication Administration	Standard Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR): A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for:</p> <ol style="list-style-type: none"> 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. <ol style="list-style-type: none"> 1. Including the following on the MAR: <ol style="list-style-type: none"> 1. The name of the person, a transcription of the physician’s or licensed health care provider’s orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; 2. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the counter (OTC) or “comfort” medications or treatments and all self- 	<p>Medication Administration Records (MAR) were reviewed for the months of August 2019 and September 2019.</p> <p>Based on record review, 13 of 13 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</p> <p>Individual #3 August 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Ativan 2 mg (2 times daily) • Clonidine 0.1 mg (2 times daily) • Seroquel 200 mg (2 times daily) • Thera-M (1 time daily) <p>September 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Clonidine 0.1 mg (2 times daily) • Lorazepam 2mg (2 times daily) • Quetiapine 200 mg (1 time daily) • Quetiapine 300 mg (1 time daily) • Thera-M (1 time daily) <p>Individual #4 August 2019</p>	<p>New/Repeat Finding:</p> <p>Medication Administration Records (MAR) were reviewed for the month of March 2020.</p> <p>Based on record review, 2 of 11 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</p> <p>Individual #4 March 2020 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Ferrous Gluc 324 mg (1 time daily) <p>Individual #6 March 2020 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Oxybutynin 10 mg ER tab (1 time daily)

<p>selected herbal or vitamin therapy;</p> <ol style="list-style-type: none"> 3. Documentation of all time limited or discontinued medications or treatments; 4. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; 5. Documentation of refused, missed, or held medications or treatments; 6. Documentation of any allergic reaction that occurred due to medication or treatments; and 7. For PRN medications or treatments: <ol style="list-style-type: none"> 1. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; 2. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and 3. documentation of the effectiveness of the PRN medication or treatment. <p>Chapter 10 Living Care Arrangements 10.3.4 Medication Assessment and Delivery: Living Supports Provider Agencies must support and comply with:</p> <ol style="list-style-type: none"> 4. the processes identified in the DDS AWMD training; 5. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 6. all Board of Pharmacy regulations as noted in 	<p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Alendronate 70 mg (1 time weekly) • Ferrous Gluc 324 mg (1 time daily) • Omeprazole 20 mg (1 time daily) • Triamcinolone 0.1% cream (2 times daily) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Triamcinolone 0.1% cream (2 times daily) <p>Individual #5 August 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Amlodipine Besylate 10mg (1 time daily) • Aripirazole 2mg (1 time daily) • Carvedilol 12.5mg (2 times daily) • Docusate Sodium (1 time daily) • Fluticasone 50mcg (1 time daily) • Loratadine 10mg (1 time daily) • Losartan Potassium 25mg (1 time daily) • Magnesium Oxide 400mg (1 time daily) • Mycophenolic 180mg (3 times daily) 	
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<p>Chapter 16.5 Board of Pharmacy; and 7. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. <p>Model Custodial Procedure Manual D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p>	<ul style="list-style-type: none"> • Nortrel 1-35 (1 time daily) • Sertraline HCL 50mg (1 time daily) <p>September 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Nortrel 1-35 (1 time daily) • Nystatin Topical Powder (1 time daily) • Sertraline HCL 50mg (1 time daily) • Sirolimus .5mg (1 time daily) • Trulicity Injectable .75/.5 (1 time weekly) <p>Individual #6 August 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Furosemide 20mg (1 time daily for 14 days) • Memantine HCL 5mg (2 times daily) • Metronidazole .75% cream (2 times daily) <p>Individual #8 August 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Cetirizine 10mg (1 time daily) <p>September 2019</p>	
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<p>8. symptoms that indicate the use of the medication,</p> <p>9. exact dosage to be used, and</p> <p>10. the exact amount to be used in a 24-hour period.</p>	<p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Denta 5000 plus care cream w/f prevalent 5000 brush (1 time daily) <p>Individual #9 August 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Lantus Solostar injection 12 units (1time daily) • Metformin 500mg ER (1 time daily) <p>September 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Flutic/SalmeAer 250/50 (2 times daily) • Flutocaone 50 mcg (1 time daily) • Lontus Solostar Injection 12 units (1 time daily) • Metformin 500mg ER (1 time daily) <p>Individual #10 August 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Antacid 500mg (1 time daily) <p>September 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Antacid 500mg (1 time daily) 	
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	<p>Individual #11 August 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • B-Complex capsules (1 time daily) <p>September 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Polyethylene Glyc Pow 3350 NF (1 time daily) • Vitamin B12 100mg (1 time daily) • Vitamin C 1000mg (1 time daily) <p>Individual #12 August 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Buspirone 15mg tablets (3 times daily) • Calcium + D3 (1 time daily) • Chlorhexidine Gluc 0.12% (2 times daily) • Divalproex 125mg (1 time daily) <p>September 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Benztropine 1mg (1 time daily) <p>Individual #13 August 2019</p>	
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	<p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Deep Sea 0.65% spray (3 times daily) • Escitalopram 20mg (1 time daily) • Fluticasone 50mcg (1 time daily) • Metformin 500mg (1 time daily) • Omeprazole 40mg (1 time daily) <p>September 2019</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Azelastine 0.1% NS (2 times daily) • Benztropine 1mg (1 time daily) • Deep Sea 0.65% (3 times daily) • Fluticasone 50mcg (1 time daily) • Metformin 500mg (1 time daily) • Omeprazole 40mg (1 time daily) • Oxybutynin 5mg (3 times daily) <p>Individual #14</p> <p>August 2019</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Gabapentin 100mg (2 times daily) • Gabapentin 300mg (3 times daily) 	
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	<ul style="list-style-type: none"> • Levetiracetam 100mg (2 times daily) <p>September 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Bentropine .5mg (1 time daily) • Carbamazepine 200mg (3 times daily) • Citalopram 40mg (1 time daily) • Gabapentin 100mg (2 times daily) • Gabapentin 300mg (3 times daily) • Levetiracetam 100mg (2 times daily) • Levothyroxine 125 mg (1 time daily) • Tamsulosin 0.4mg (1 time daily) <p>Individual #15 August 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Carb/Levo 25-100mg (4 times daily) • Oxcarbazepine 600mg (2 times daily) <p>September 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Carb/Levo 25-100mg (4 times daily) • Mupirocin 2% ointment (2 times daily) 	
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	<ul style="list-style-type: none"> • Oxcarbazepine 600mg (2 times daily) <p>September 2019 Medication Administration Record did not contain the time the medication should be given.</p> <ul style="list-style-type: none"> • Mupirocin 2% ointment (2 times daily) <p>Individual #16 August 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Divalproex 250mg (1 time daily) • Ketoconazole cream 2% (1 time daily) • Lamotrigine 150mg (2 times daily) • Lantus Solostar Inj 22 units (1 time daily) • Omeprozole 20mg (1 time daily) • Refresh Plus Drops .5% Op (4 times daily) • Tamsulosin 0.4mg (1 time daily) • Vitamin B12 1000mcg (1 time daily) <p>September 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Divalproex 250mg (1 time daily) • Ketoconazole cream 2% (1 time daily) • Lamotrigine 150mg (2 times daily) 	
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|--|---|--|
| | <ul style="list-style-type: none">• Minerin Cream (3 times weekly)• Omeprazole 20mg (1 time daily)• Tamsulosin 0.4mg (1 time daily) | |
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Tag # 1A09.1 Medication Delivery PRN Medication Administration	Condition of Participation Level Deficiency	Condition of Participation Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR): A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP.</p> <p>Primary and Secondary Provider Agencies are responsible for:</p> <ol style="list-style-type: none"> 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. <ol style="list-style-type: none"> 1. Including the following on the MAR: <ol style="list-style-type: none"> 1. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; 2. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; 3. Documentation of all time limited or discontinued medications or treatments; 	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Medication Administration Records (MAR) were reviewed for the months of August 2019 and September 2019.</p> <p>Based on record review, 3 of 13 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard:</p> <p>Individual #4 August 2019 No evidence of documented Signs / Symptoms were found for the following PRN medications: • Acetaminophen 500mg – PRN – 8/7 (given 2 times).</p> <p>No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 500mg – PRN – 8/7 (given 2 times)</p> <p>Individual #5 August 2019 No evidence of documented Signs / Symptoms were found for the following PRN medication: • Amoxicillin 500mg – PRN – 8/21 (given 1 time).</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Amoxicillin 500mg – PRN – 8/21 (given 1 time)</p>	<p>New/Repeat Findings:</p> <p>Medication Administration Records (MAR) were reviewed for the month of March 2020.</p> <p>Based on record review, 2 of 11 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard:</p> <p>Individual #4 March 2020 No evidence of documented Signs / Symptoms were found for the following PRN medication: • Loperamide 2 mg – PRN - 3/29 (given 1 time)</p> <p>• Lorazepam 1mg – PRN - 3/30 (given 2 times).</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Loperamide 2 mg – PRN - 3/29 (given 1 time)</p> <p>• Lorazepam 1mg – PRN – 3/30 (given 2 times).</p> <p>No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Loperamide 2 mg – PRN – 3/29 (given 1 time)</p> <p>• Lorazepam 1mg – PRN – 3/30 (given 2 times)</p> <p>Medication Administration Records Indicated Loperamide 2 mg (2 tablets) was given. MAR did not indicate the exact dosage (2 tablets) each time the med was assisted or administered for the following date: • 3/29</p>

<p>4. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials;</p> <p>5. Documentation of refused, missed, or held medications or treatments;</p> <p>6. Documentation of any allergic reaction that occurred due to medication or treatments; and</p> <p>7. For PRN medications or treatments:</p> <ol style="list-style-type: none"> 1. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; 2. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and 3. documentation of the effectiveness of the PRN medication or treatment. <p>Chapter 10 Living Care Arrangements 10.3.4 Medication Assessment and Delivery: Living Supports Provider Agencies must support and comply with:</p> <ol style="list-style-type: none"> 1. the processes identified in the DDSD AWMD training; 2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR). 	<ul style="list-style-type: none"> •Acetaminophen 500mg – PRN – 8/25 – 29 <p>No Time of Administration was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> •Acetaminophen 500mg– PRN – 8/25 – 29 <p>Individual #12 August 2019</p> <p>No evidence of documented Signs / Symptoms were found for the following PRN medication:</p> <ul style="list-style-type: none"> • Benadryl – PRN – 8/31 (given 2 times) <p>No Time of Administration was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Benadryl – PRN –8/31 <p>September 2019</p> <p>No Time of Administration was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Benadryl - PRN – 8/31 	<p>Medication Administration Records Indicated Lorazepam 1mg (1 tablet) was given. MAR did not indicate the exact dosage (1 tablet) each time the med was assisted or administered for the following date:</p> <ul style="list-style-type: none"> • 3/30 <p>Individual #5 March 2020</p> <p>As indicated by the Medication Administration Records the individual is to take Acetaminophen 500mg (PRN). According to the Physicians Orders, Acetaminophen 325mg is to be taken as needed for pain. Medication Administration Record and Physician’s Orders do not match.</p>
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Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Condition of Participation Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.</p> <p>DD Waiver Provider Agencies are required to adhere to the following:</p> <p>Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.</p> <p>Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable.</p> <p>Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.</p> <p>Each Provider Agency is responsible for maintaining the daily or other contact notes</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 9 of 15 individual.</p> <p>Review of the administrative individual case files revealed the following items were not found, were incomplete, and/or not current:</p> <p>Healthcare Passport:</p> <ul style="list-style-type: none"> • Did not contain current Guardianship/ Healthcare Decision Maker (#13) <p>Health Care Plans:</p> <p>Aspiration:</p> <ul style="list-style-type: none"> • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. <p>Cholesterol:</p> <ul style="list-style-type: none"> • Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. <p>Constipation:</p> <ul style="list-style-type: none"> • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Evidence indicated the plan was not current. <p>Falls:</p>	<p>Repeat Finding:</p> <p>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 2 of 13 individual.</p> <p>Review of the administrative individual case files revealed the following items were not found, were incomplete, and/or not current:</p> <p>Health Care Plans:</p> <p>Cholesterol:</p> <ul style="list-style-type: none"> • Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. <p>Fluid Monitoring:</p> <ul style="list-style-type: none"> • Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. <p>Medical Emergency Response Plans:</p> <p>Cardiac Condition:</p> <ul style="list-style-type: none"> • Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.

<p>documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. All records pertaining to JCMs must be retained permanently and must be made available to DDS upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p>Chapter 3 Safeguards: 3.1.1 Decision Consultation Process (DCP): Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following:</p> <ol style="list-style-type: none"> 1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: <ol style="list-style-type: none"> a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have 	<ul style="list-style-type: none"> • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. <p>Fluid Monitoring:</p> <ul style="list-style-type: none"> • Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. <p>Oral Care:</p> <ul style="list-style-type: none"> • Individual #12 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Plan not Linked or Attached in Therap. <i>(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)</i> <p>Pain:</p> <ul style="list-style-type: none"> • Individual #13 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Plan not Linked or Attached in Therap. <i>(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)</i> <p>Respiratory:</p> <ul style="list-style-type: none"> • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Evidence indicated the plan was not current. • Individual #13 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. <p>Seizure Disorder:</p>	
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<p>performed an evaluation such as a video-fluoroscopy;</p> <p>c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and</p> <p>d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.</p> <p>2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting:</p> <ol style="list-style-type: none"> 1. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman’s terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. 2. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation. <p>c. Providers support the person/guardian to make an informed decision.</p> <p>d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting.</p> <p>Chapter 13 Nursing Services: 13.2.5 Electronic Nursing Assessment and Planning Process: The nursing assessment process includes several DDSD mandated tools: the electronic</p>	<ul style="list-style-type: none"> • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Evidence indicated the plan was not current. • Individual #12 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Plan not Linked or Attached in Therap. <i>(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)</i> <p>Skin and Wound:</p> <ul style="list-style-type: none"> • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Evidence indicated the plan was not current. <p>Sodium:</p> <ul style="list-style-type: none"> • Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. <p>Status of Care:</p> <ul style="list-style-type: none"> • Individual #10 - As indicated by the IST section of ISP the individual is required to have a plan. Plan not Linked or Attached in Therap. <i>(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)</i> <p>Unplanned Weight Loss:</p> <ul style="list-style-type: none"> • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Evidence indicated the plan was not current. <p>Medical Emergency Response Plans: Aspiration:</p>	
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<p>Comprehensive Nursing Assessment Tool (e-CHAT), the Aspiration Risk Screening Tool (ARST) and the Medication Administration Assessment Tool (MAAT). This process includes developing and training Health Care Plans and Medical Emergency Response Plans.</p> <p>The following hierarchy is based on budgeted services and is used to identify which Provider Agency nurse has primary responsibility for completion of the nursing assessment process and related subsequent planning and training. Additional communication and collaboration for planning specific to CCS or CIE services may be needed.</p> <p>The hierarchy for Nursing Assessment and Planning responsibilities is:</p> <p>Living Supports: Supported Living, IMLS or Family Living via ANS; Customized Community Supports- Group; and Adult Nursing Services (ANS):</p> <ol style="list-style-type: none"> 1. for persons in Community Inclusion with health-related needs; or 2. if no residential services are budgeted but assessment is desired and health needs may exist. <p>13.2.6 The Electronic Comprehensive Health Assessment Tool (e-CHAT)</p> <p>The e-CHAT is a nursing assessment. It may not be delegated by a licensed nurse to a non-licensed person.</p> <p>The nurse must see the person face-to-face to complete the nursing assessment. Additional information may be gathered from members of the IDT and other sources.</p> <p>An e-CHAT is required for persons in FL, SL, IMLS, or CCS-Group. All other DD Waiver recipients may obtain an e-CHAT if needed or desired by adding ANS hours for assessment and consultation to their budget.</p>	<ul style="list-style-type: none"> • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a current plan found. <p>Bowel and Bladder:</p> <ul style="list-style-type: none"> • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a current plan found. <p>Cardiac Condition:</p> <ul style="list-style-type: none"> • Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. <p>Falls:</p> <ul style="list-style-type: none"> • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. <p>Respiratory:</p> <ul style="list-style-type: none"> • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a current plan found. <p>Seizures:</p> <ul style="list-style-type: none"> • Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a current plan found. • Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • Individual #12 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Plan not 	
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<p>When completing the e-CHAT, the nurse is required to review and update the electronic record and consider the diagnoses, medications, treatments, and overall status of the person. Discussion with others may be needed to obtain critical information. The nurse is required to complete all the e-CHAT assessment questions and add additional pertinent information in all comment sections.</p> <p>13.2.7 Aspiration Risk Management Screening Tool (ARST)</p> <p>13.2.8 Medication Administration Assessment Tool (MAAT): A licensed nurse completes the DDSD Medication Administration Assessment Tool (MAAT) at least two weeks before the annual ISP meeting. After completion of the MAAT, the nurse will present recommendations regarding the level of assistance with medication delivery (AWMD) to the IDT. A copy of the MAAT will be sent to all the team members two weeks before the annual ISP meeting and the original MAAT will be retained in the Provider Agency records. Decisions about medication delivery are made by the IDT to promote a person's maximum independence and community integration. The IDT will reach consensus regarding which criteria the person meets, as indicated by the results of the MAAT and the nursing recommendations, and the decision is documented this in the ISP.</p> <p>13.2.9 Healthcare Plans (HCP): 1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or</p>	<p>Linked or Attached in Therap. <i>(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)</i></p> <p>Status of Care/Hygiene:</p> <ul style="list-style-type: none"> Individual #15 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a current plan found. 	
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change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans.

2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary report which is indicated by "R" in the HCP column. At the nurse's sole discretion, based on prudent nursing practice, HCPs may be combined where clinically appropriate. The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by "C" on the e-CHAT summary report. The nurse may also create other HCPs plans that the nurse determines are warranted.

13.2.10 Medical Emergency Response Plan (MERP):

The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP.

MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.

Chapter 20: Provider Documentation and Client Records: 20.5.3 Health Passport and Physician Consultation Form: All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap

system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form.

Standard of Care	Routine Survey Deficiencies September 13 – 19, 2019	Verification Survey New and Repeat Deficiencies April 6 –17, 2020
<i>Service Domain: Service Plans: ISP Implementation - Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.</i>		
Tag # 1A08 Administrative Case File (Other Required Documents)	Standard Level Deficiency	COMPLETE
Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	Standard Level Deficiency	COMPLETE
Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)	Standard Level Deficiency	COMPLETE
Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)	Standard Level Deficiency	COMPLETE
Tag # IS04 Community Life Engagement	Standard Level Deficiency	COMPLETE
Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	Standard Level Deficiency	COMPLETE
Tag # 1A38.1 Living Care Arrangement / Community Inclusion Reporting Requirements (Reporting Components)	Standard Level Deficiency	COMPLETE
Tag # IS12 Person Centered Assessment (Community Inclusion)	Standard Level Deficiency	COMPLETE
Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)	Condition of Participation Level Deficiency	COMPLETE
Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)	Standard Level Deficiency	COMPLETE
<i>Service Domain: Qualified Providers – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.</i>		
Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency	COMPLETE
Tag # 1A22 Agency Personnel Competency	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A25.1 Caregiver Criminal History Screening	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	Standard Level Deficiency	COMPLETE
Tag # 1A37 Individual Specific Training	Condition of Participation Level Deficiency	COMPLETE

Tag # 1A43.1 General Events Reporting: Individual Reporting	Standard Level Deficiency	COMPLETE
<i>Service Domain: Health and Welfare – The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.</i>		
Tag # 1A03 Continuous Quality Improvement System & Key Performance Indicators (KPIs)	Standard Level Deficiency	COMPLETE
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	Standard Level Deficiency	COMPLETE
Tag # 1A09.1.0 Medication Delivery PRN Medication Administration	Standard Level Deficiency	COMPLETE
Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A31 Client Rights / Human Rights	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A33.1 Board of Pharmacy - License	Standard Level Deficiency	COMPLETE
Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	Standard Level Deficiency	COMPLETE
Standard of Care	Routine Survey Deficiencies September 13 - 19, 2019	Verification Survey New and Repeat Deficiencies April 6 –17, 2020
<i>Service Domain: Medicaid Billing/Reimbursement – State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</i>		
Tag # IS30 Customized Community Supports Reimbursement (Revised)	Standard Level Deficiency	COMPLETE
Tag # LS27 Family Living Reimbursement	Standard Level Deficiency	COMPLETE

	Verification Survey Plan of Correction, On-going QA/QI and Responsible Party	COMPLETION DATE
<p>Tag # 1A09 Medication Delivery Routine Medication Administration</p>	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>[]</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p> <p>[]</p>	<p> </p>
<p>Tag # 1A09.0 Medication Delivery Routine Medication Administration</p>	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>[]</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p> <p>[]</p>	<p> </p>

<p>Tag # 1A09.1 Medication Delivery PRN Medication Administration</p>	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>[]</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p> <p>[]</p>	<p> </p>
<p>Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)</p>	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>[]</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p> <p>[]</p>	<p> </p>

Date: June 23, 2020

To: Johnathan Baca, Executive Director
Provider: Bright Horizons, Inc.
Address: 3809 Academy Parkway S. NE
City, State/Zip: Albuquerque, New Mexico 87109

E-mail Address: jonb@brighthorizonsnm.com
rebecca@brighthorizonsnm.com

Board Chair E-Mail
Address: kimberlyallenm@gmail.com

Region: Metro
Routine Survey: September 13 – 19, 2019
Verification Survey: April 6, 2020 – 17, 2020

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2018:** Supported Living, Family Living; Customized In-Home Supports;
Customized Community Supports, and Community Integrated
Employment Services

Survey Type: Verification

Dear Mr. Baca:

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

The Plan of Correction process is now complete.

Furthermore, your agency is now determined to be in Compliance with all Conditions of Participation.

To maintain ongoing compliance with standards and regulations, continue to use the Quality Assurance (self-auditing) processes you described in your Plan of Correction.

Consistent use of these Quality Assurance processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies cited in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, for striving to come into compliance with standards and regulations, and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,

Monica Valdez, BS

Monica Valdez, BS
Healthcare Surveyor Advanced/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.20.4.DDW.D2079.5. VER 09.20.175