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| Date: | March 3, 2010 |
| To: | Ana Marie Carrillo, Service Coordinator/Owner |
| Provider: | Carlacare, Inc. |
| Address: | 1988 Crescent Drive |
| State/Zip: | Las Cruces, NM 88001 |
| E-mail Address: | carrillr@q.com |
| CC: | Richard Carrillo, Owner |
| Address: | 1988 Crescent Drive |
| State/Zip: | Las Cruces, NM 88001 |
| Region: | Southwest |
| Survey Date: | February 11 & 17, 2010 |
| Program Surveyed: | Developmental Disabilities Waiver |
| Service Surveyed: | Community Living (Support Living) |
| Survey Type: | Routine |
| Team Leader: | Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau |
| Team Members: | Cheryl Dunfee, Case Management Coordinator, Developmental Disabilities Support Division/Southwest Regional Office |

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

**Quality Management Approval Rating:**
The Division of Health Improvement is pleased to issue your agency a "MERIT" rating for compliance with DDSD Standards and regulations.

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

1. Quality Management Bureau, Attention: Plan of Correction Coordinator
   5301 Central Ave. NE Suite 400 Albuquerque, NM 87108

2. Developmental Disabilities Supports Division Regional Office for region of service surveyed.

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

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

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

QMB Deputy Bureau Chief
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request

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

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

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

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

Sincerely,

Deb Russell, BS

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

## Survey Process Employed:

| | |
|---|---|
| Entrance Conference Date: | February 11, 2010 |
| Present: | **Carlacare**<br>Ana Marie Carrillo, Service Coordinator/Owner<br>Richard Carrillo, Owner<br><br>**DOH/DHI/QMB**<br>Deb Russell, BS, Team Lead/Healthcare Surveyor<br><br>**DDSD - Southwest Regional Office**<br>Cheryl Dunfee, Case Management Coordinator |
| Exit Conference Date: | February 11, 2010 |
| Present: | **Carlacare**<br>Ana Marie Carrillo, Service Coordinator/Owner<br>Richard Carrillo, Owner<br><br>**DOH/DHI/QMB**<br>Deb Russell, BS, Team Lead/Healthcare Surveyor<br><br>**DDSD - Southwest Regional Office**<br>Cheryl Dunfee, Case Management Coordinator |
| Homes Visited | Number: 1 |
| Administrative Locations Visited | Number: 1 |
| Total Sample Size | Number: 1<br>0 - Jackson Class Member<br>1 - Non-Jackson Class Member<br>1 - Supported Living |
| Persons Served Interviewed | Number: 1 |
| Records Reviewed (Persons Served) | Number: 1 |
| Administrative Files Reviewed | • Billing Records<br>• Medical Records<br>• Incident Management Records<br>• Personnel Files<br>• Training Records<br>• Agency Policy and Procedure<br>• Caregiver Criminal History Screening Records<br>• Employee Abuse Registry<br>• Human Rights Notes and/or Meeting Minutes<br>• Nursing personnel files<br>• Evacuation Drills<br>• Quality Improvement/Quality Assurance Plan |

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

**Attachment A**

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8647.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency ("Responsible Party"), and by WHEN ("Date Due").
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues to prevent the Deficiency from reoccurring, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency's Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to George.Perrault@state.nm.us, by fax (505-222-8661), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been "Approved" or "Denied".
- Whether your POC is "Approved" or "Denied", you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is "Denied" it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- The following Deficiencies must be corrected within the deadlines below (after receipt of your Survey Report):

    - CCHS and EAR: 10 working days
    - Medication errors: 10 working days
    - IMS system/training: 20 working days
    - ISP related documentation: 30 working days
    - DDSD Training 45 working days

- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8647 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.
- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by-case basis.
- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual #s.
- Do not submit original documents, hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

**Attachment B**

## QMB Scope and Severity Matrix of survey results

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

| | | | SCOPE | | |
|---|---|---|---|---|---|
| | | | **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.

**The QMB Approval Rating**

The QMB approval rating is the provider incentive to encourage quality service and correlates the review outcome with the QMB review frequency and its recommendation to DDSD to determine the length of the provider agreement. The "Approval rating" is based on the Scope and Severity of the review findings. There are five levels of "Approval" that a provider may receive. They are:

"Quality" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Quality" Rating. To qualify for a QMB "Quality" rating of approval" and a three (3) year QMB review cycle and provider agreement recommendation, the provider must not have any findings that are a condition of participation and no findings of "F" level or higher on the Scope and Severity Matrix with no more that three (3) D or E level findings.

"Merit" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Merit" Rating. To qualify for a QMB "Merit" rating of approval" and a two (2) year QMB review cycle and provider agreement recommendation, the provider must not have more than three (3) findings that are a condition of participation and no more than three (3) "F" level findings with no findings of a "G" level or higher on the Scope and Severity Matrix and no more that six (6) D or E level findings.

"Standard" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Standard" Rating. To qualify for a QMB "Standard" rating of approval" and a one (1) year QMB review cycle and provider agreement recommendation, the provider must not have more than six (6) findings that are a condition of participation and no more than six (6) "F" level findings with no findings of a "G" level or higher on the Scope and Severity Matrix and no more that six (6) D or E level findings.

"Sub-Standard" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider has "Sub-standard" performance. To qualify for a QMB "Sub-Standard" rating of approval" and a three to six month QMB review cycle, with a referral to the Internal Review Committee and provider agreement recommendation, the provider may have any of the following findings:

- seven (7) or more findings that are a condition of participation
- seven (7) or more "F" level findings
- any findings of a "G" level or higher
- nine (9) or more D or E level findings

A referral to the IRC is required for any "Sub-standard" rating. Depending upon the egregious nature of the findings the IRC shall take appropriate sanction actions up to and including contract termination.

"Provisional" Approval Rating:
New DD service providers may qualify for a QMB "Provisional" Approval Rating upon successfully completing their initial QMB Quality Survey.
The QMB DD Manager will review the Report of Findings and determine if the provider has achieved at least a standard rating of approval. If successful, the provider may receive a one (1) year contract extension. QMB will notify the DDSD Contract unit of the "Provisional" approval rating.

**Attachment C**

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

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

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

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

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

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

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

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

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

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

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

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

**Agency:** **Carlacare, Inc. - Southwest Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living)
Monitoring Type: Routine Survey
**Date of Survey:** **February 11 & 17, 2010**

| Statute | Deficiency | Agency Plan of Correction and Responsible Party | Date Due |
|---|---|---|---|
| **Tag # 1A09 Medication Delivery (MAR) - Routine Medication** | **Scope and Severity Rating: F** | | |
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**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.<br>**E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.<br><br>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:<br>(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, | Medication Administration Records (MAR) were reviewed for the months of November, December 2009 and January 2010.<br><br>Based on record review, 1 of 1 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:<br><br>Individual #1<br>January 2010<br>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:<br>• Azithromycin (1 time daily) | | |

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| diagnosis for which the medication is prescribed;<br>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;<br>(c) Initials of the individual administering or assisting with the medication;<br>(d) Explanation of any medication irregularity;<br>(e) Documentation of any allergic reaction or adverse medication effect; and<br>(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.<br>(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;<br>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;<br>(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 administrating the medication, signs and symptoms of adverse events and interactions with other medications;<br><br>**NMAC 16.19.11.8 MINIMUM STANDARDS:**<br>A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:<br><br>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: | | | |

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| (i) Name of resident;<br>(ii) Date given;<br>(iii) Drug product name;<br>(iv) Dosage and form;<br>(v) Strength of drug;<br>(vi) Route of administration;<br>(vii) How often medication is to be taken;<br>(viii) Time taken and staff initials;<br>(ix) Dates when the medication is discontinued or changed;<br>(x) The name and initials of all staff administering medications.<br><br>**Model Custodial Procedure Manual**<br>***D. Administration of Drugs***<br>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.<br><br>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:<br>➢ symptoms that indicate the use of the medication,<br>➢ exact dosage to be used, and<br>➢ the exact amount to be used in a 24 hour period. | | | |

| Tag # 1A09.2 Medication Delivery - PRN Medication | Scope and Severity Rating: F | | |
|---|---|---|---|
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**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.<br>**E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.<br><br>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:<br>(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;<br>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;<br>(c) Initials of the individual administering or assisting with the medication;<br>(d) Explanation of any medication irregularity;<br>(e) Documentation of any allergic reaction or | Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 1 of 1 Individuals.<br><br>Individual #1<br>December 2009<br>No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication:<br>• Fexofenodine 180mg – PRN – 12/1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 & 19. (given 1 time daily)<br><br>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:<br>• Fexofenodine 180mg – PRN – 12/1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 & 19. (given 1 time daily)<br><br>• Acetaminophen 325mg – PRN – 12/1 & 2 (given 1 time daily)<br><br>January 2010<br>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:<br>• Acetaminophen 325mg – PRN – 1/26 (given 1 time daily) | | |

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| adverse medication effect; and<br>(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.<br><br>(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;<br><br>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;<br><br>(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 administrating the medication, signs and symptoms of adverse events and interactions with other medications;<br><br>**NMAC 16.19.11.8 MINIMUM STANDARDS:**<br>**A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:**<br>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include:<br>(i) Name of resident;<br>(ii) Date given;<br>(iii) Drug product name;<br>(iv) Dosage and form;<br>(v) Strength of drug;<br>(vi) Route of administration;<br>(vii) How often medication is to be taken; | | | |

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| (viii) Time taken and staff initials;<br>(ix) Dates when the medication is discontinued or changed;<br>(x) The name and initials of all staff administering medications.<br><br>**Model Custodial Procedure Manual**<br>***D. Administration of Drugs***<br>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.<br><br>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:<br>➢ symptoms that indicate the use of the medication,<br>➢ exact dosage to be used, and<br>➢ the exact amount to be used in a 24 hour period.<br><br>**Department of Health**<br>**Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006**<br>**F. PRN Medication**<br>3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings | | | |

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| where the provider is related by affinity or by consanguinity to the individual.<br><br>4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy).<br><br>**H. Agency Nurse Monitoring**<br>1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication.<br><br>**Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006**<br>C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of | | | |

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| consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).<br><br>a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.<br><br>4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.). | | | |

| Tag # 1A31 (CoP) Client Rights/Human Rights | Scope and Severity Rating: F | | |
|---|---|---|---|
| **7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:**<br>A. A service provider shall not restrict or limit a client's rights except:<br>(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<br>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or<br>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].<br><br>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.<br><br>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]<br><br>**Long Term Services Division**<br>**Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003**<br>**IV. POLICY STATEMENT -** Human Rights Committees are required for residential service | Based on record review, the Agency failed to ensure the rights of Individuals was not restricted or limited for 1 of 1 Individuals. (Individual #1)<br><br>A review of Agency Individual files indicated 1 of 1 Individuals required Human Rights Committee Approval for restrictions.<br><br>No documentation was found regarding Human Rights Approval for the following:<br><br>• Psychotropic Medications to control behaviors. No evidence found of Human Rights Committee approval. (Individual #1)<br><br>Review of the Agency Policy & Procedure found no policy to address the frequency and purpose of the Human Rights Committee meetings and address Behavior Support Plans approved by the Human Rights Committee are to be reviewed at least quarterly. | | |

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| provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.<br><br>Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:<br>• Aversive Intervention Prohibitions<br>• Psychotropic Medications Use<br>• Behavioral Support Service Provision.<br><br>A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up.<br><br>**A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS**<br>Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval.<br><br>2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly.<br><br>3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual's Individual Service Plan.<br><br>**Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure** | | | |

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| **Eff Date: November 1, 2006**<br>**B. 1. e.** If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications). | | | |

## ADDITIONAL FINDINGS: Reimbursement Deficiencies

## BILLING
## TAG #1A12

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

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

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

Billing for Community Living (Family Living) services was reviewed for 1 of 1 individual. Progress notes and billing records supported billing activities for the months of October, November and December 2009.