

Date: January 15, 2016

To: David Stong, Director of Finance
Provider: Harmony Home Health Services Limited Liability Company
Address: 5650 S Green Street
State/Zip: Murray, Utah 84123

E-mail Address: davids@harmonyhomehealth.com
jennio@harmonyhomehealth.com

Region: Metro
Survey Date: December 14 - 16, 2015
Program Surveyed: Medically Fragile Waiver

Service Surveyed: Home Health Aide Services (HHAS), Private Duty Nursing (PDN) RN

Survey Type: Routine

Team Leader: Corrina B Strain, BSN, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. David Stong;

The Division of Health Improvement/Quality Management Bureau has completed a 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 Medically Fragile Waiver; and to identify opportunities for improvement. This report of findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider contracts. Upon receipt of this letter and report of findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Plan of Correction:

The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

Submission of your Plan of Correction:

Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. (See *attachment "A" for additional guidance in completing the Plan of Correction*).

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

- 1. Quality Management Bureau, Attention: Plan of Correction Coordinator
1170 N. Solano Suite D, Las Cruces, New Mexico 88001**

DIVISION OF HEALTH IMPROVEMENT • QUALITY MANAGEMENT BUREAU
5301 Central NE, Suite 400 • Albuquerque, New Mexico • 87108
(505) 222-8633 • FAX: (505) 222-8661 • <http://www.dhi.health.state.nm.us>

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 to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may 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 finding of deficient practice, you have 10 business 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

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator, Amanda Castaneda, at 575-373-5716 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Corrina B. Strain, BSN RN

Corrina B Strain, BSN, RN
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date: December 14, 2015

Present: **Harmony Home Health Services Limited Liability Company**
Michelle German, RN, Director of Nursing
Anitha Thomisee, RN, Case Manager Pediatrics

DOH/DHI/QMB

Corrina B Strain, BSN, RN, Team Lead/Healthcare Surveyor

Exit Conference Date: December 16, 2015

Present: **Harmony Home Health Services Limited Liability Company**
Michelle German, RN, Director of Nursing
Anitha Thomisee, RN, Case Manager Pediatrics

(Via telephone):

David Stong, Pediatrics Vice President, Director of Finance

Jennie Osness, Quality Assurance

D'Arcy Casady, Contracts Manager

Angie Juggert, Accounts Receivable Manager

DOH/DHI/QMB

Corrina B Strain, BSN, RN, Team Lead/Healthcare Surveyor

Administrative Locations Visited Number: 1

Total Sample Size Number: 1

Total Homes Visited Number: 1

Persons Served Records Reviewed Number: 1

Persons Served Interviewed Number: 1

Direct Support Personnel Records Reviewed Number: 7

Personnel Interviewed Number: 3

Administrative Files Reviewed:

- Billing Records/Process
- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry Documentation
- Quality Assurance / Improvement Plan

CC Distribution List: Department Health Improvement (DHI) - File
Developmental Disabilities Support Division (DDSD)
Medical Fragile Program Director
Human Services Department (HSD)

Attachment A

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

Introduction:

After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued deficiencies and non-compliance.

Agencies must submit their Plan of Correction within ten (10) business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days may be referred to the Internal Review Committee [IRC] for possible actions or sanctions).

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings (Providers who fail to complete a POC within the 45 business days allowed will be referred to the IRC for possible actions or sanctions.)

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us. Requests for technical assistance must be requested through your Regional DDS Office.

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment "C").

Instructions for Completing Agency POC:

Required Content

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

The Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and

5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
6. The POC must be signed and dated by the agency director or other authorized official.

The following details should be considered when developing your Plan of Correction:

- Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
- Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc;
- How accuracy in Billing/Reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how Individual Specific Plans are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to Quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

Note: Instruction or in-service of staff alone may not be a sufficient plan of correction. This is a good first step toward correction, but additional steps should be taken to ensure the deficiency is corrected and will not recur.

Completion Dates

- The plan of correction must include a **completion date** (entered in the far right-hand column) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Amanda E Castaneda at 575-373-5716 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda E. Castaneda, POC Coordinator in any of the following ways:
 - a. Electronically at AmandaE.Castaneda@state.nm.us (preferred method)
 - b. Fax to 575-528-5019, or
 - c. Mail to POC Coordinator, 1170 N. Solano Suite D, Las Cruces , NM 88001
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approved” or “denied.”
 - a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
 - b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
 - c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.

- d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
 - e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (scanned and attached to e-mails).
3. All submitted documents must be annotated; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC. for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:
 - a. Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
 - b. Copies of “void and adjust” forms submitted to Xerox State Healthcare, LLC. to correct all unjustified units identified and submitted for payment during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

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 Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
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: <http://dhi.health.state.nm.us/qmb>
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, Crystal Lopez-Beck at crystal.lopez-beck@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.

Agency: Harmony Home Health Services Limited Liability Company– Metro Region
Program: Medically Fragile Waiver
Service: Home Health Aide Services (HHAS); Private Duty Nursing (PDN)
Monitoring Type: Routine Survey
Survey Dates: December 14 – 16, 2015

Statutes	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
TAG # MF04 General Provider Requirements			
<p>New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Waiver (MFW) effective 1/01/2011</p> <p>GENERAL AUTHORITY: The following Laws and standards, policies and procedures governing the provision of services under the Medically Fragile Medicaid Waiver include, but are not limited to:</p> <p>*The Centers for Medicare and Medicaid Services (CMS) Requirements for Home and Community-Based Service Waivers</p> <p>*CMS Rulings such as decisions of the Administrator, precedent final opinions, orders and statements of policy and interpretation</p> <p>*Health Insurance Portability and Accountability Act (HIPAA) of 1996, including the CMS Administrative Simplification Provisions</p> <p>*New Mexico Human Services Department (HSD) Medicaid Policy Manual, Medically Fragile Home and Community-Based Services Waiver Services ([8.314.3 New Mexico Administrative Code (NMAC)]; including Manual Revision Memorandum 10-29</p>	<p>Based on record review the Agency did not ensure that written policies and procedures were reviewed at least every three years and updated.</p> <p>Review of the Agency's policies and procedures revealed the following:</p> <p>The following policies and procedures showed no evidence of being reviewed every three years or being updated as needed:</p> <ul style="list-style-type: none"> • Incident Reporting/ANE (Abuse, Neglect, Exploitation) - No date found indicating-when policy was last revised. • Professional Advisory Group (QA) - No date found indicating when policy was last revised. • Driving Policy - No date found indicating when policy was last revised. • Transportation of Patients Policy -No date found indicating when policy was last revised. • Standards of Conduct/Ethical Behavior - No date found indicating when policy was last revised. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>*Final Registers Vol. 33 No. 54 Medically Fragile Home and Community-Based Services Waiver</p> <p>* HSD Medicaid Program Policy Manual</p> <p>*HSD Medicaid Billing Instructions for the Disabled and Elderly, Medically Fragile, HIV/AIDS, and Developmental Disabilities Waivers (8.314 BI)</p> <p>*HSD Medical Assistance Division Provider Participation Agreement (MAD 335)</p> <p>*Fair Labor Standards Act of 1938 (FLSA), as amended 29 USC §201 et seq.; 29CFR Parts 510 to 794</p> <p>*Pharmacy Act (Chapter 61, Article 11 NMSA 1978)</p> <p>*New Mexico Nursing Practice Act, Chapter 61, Article 3, New Mexico Statute Authority (NMSA)</p> <p>*Certified Medication Aide Rules (16.12.5. NMAC)</p> <p>*The DDS Home and Community-Based Waiver Provider Agreement</p> <p>*DOH/DDS Client Complaint Procedures (7.26.4 NMAC)</p> <p>*Long Term Services – Waivers Medically Fragile Home and Community –Based Services Waiver Services (8.314.3 NMAC)</p> <p>*Medicaid Eligibility – Home and Community-Based Services (8.290.400. NMAC)</p> <p>*Medicaid General Provider Policies (8.302.1 NMAC)</p> <p>GENERAL PROVIDER REQUIREMENTS:</p> <p>These standards apply to call services provided through the Medicaid Home and Community-</p>			
---	--	--	--

<p>Based Services Waiver Program of participants with the Medically Fragile Waiver (MFW). These standards interpret and further enforce the New Mexico Human Services Department (HSD) Medicaid Policy Manual for MFW and the Centers for Medicare and Medicaid Services (CMS) requirements for Home and Community-Based Service Waivers.</p> <p>I. <u>Provider Requirements</u></p> <p>A. The Medicaid Medically Fragile Home and Community Based Services Waiver requires providers to meet any pertinent laws, regulations, rules, policies and interpretive memoranda published by the New Mexico Department of Health (DOH) and HSD.</p> <p>B. All providers must be currently enrolled as a MFW provider through the Developmental Disabilities' Supports Division (DDSD) Provider Enrollment Unit process. Reference: http://nmhealth.org/ddsd/providerinformation/ProviderEnrollmentApplicationPage.htm</p> <p>C. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures.</p> <p>D. All provider agencies that enter into a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies and standards. Reference: http://dhi.health.state.nm.us/</p> <p>E. Provider Agency Report of Changes in Operations:</p> <ol style="list-style-type: none"> 1. The provider agency shall notify the DOH in writing of any changes in the disclosures required in this section within ten (10) calendar days. This notice shall include information and documentation regarding such changes as the following: any 			
--	--	--	--

<p>change in the mailing address of the provider agency, and any change in executive director, administrator and classification of any services provided.</p> <p>F. Program Flexibility:</p> <p>1. If the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects conflicts with these standards, then prior written approval from the DOH shall be obtained. Such approval shall provide for the terms and conditions under which the waiver of specific standard(s) is/are granted. The applicant or provider agency is required to submit a written request and attach substantiating evidence supporting the request to DOH. DOH will only approve requests that remain consistent with the current federally approved MFW application.</p> <p>G. Continuous Quality Management System:</p> <p>1. On an annual basis, MFW provider agencies shall update and implement the request, the agency will submit a summary of each year's quality improvement activities and resolutions to the MFW Program Manager.</p> <p>H. The provider agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and that comply with all DDSD policies and procedures and all relevant New Mexico statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.</p> <p>I. Appropriate planning shall take place with</p>			
---	--	--	--

<p>all Interdisciplinary Team (IDT) members, Medicaid SALUD provider, other waiver providers and school services to facilitate a smooth transition from the MFW program. The participant's individual choices shall be given consideration when possible. DOH policies must be adhered to during this process as per the provider's contract.</p> <p>J. All provider agencies, in addition to requirements under each specific service standard, shall at a minimum develop, implement and maintain at the designated provider agency main office, documentation of policies and procedures for the following:</p> <ol style="list-style-type: none"> 1. Coordination with other provider agency staff serving individuals receiving MFW services that delineates the specific roles of each agency staff. 2. Response to the individual emergency medical situations, including staff training for emergency response and on-call systems as indicated. 3. Agency protocols for disaster planning and emergency preparedness. <p>K. Participant Transition to a Different Provider Agency:</p> <ol style="list-style-type: none"> 1. When a waiver participant is transferred to a similar provider agency, the receiving agency shall be provided the minimum following records: <ol style="list-style-type: none"> a. Complete file for the last 12 months b. Current and prior year Individualized Service Plan (ISP) c. Intake information from original admission to services <p>L. Provider Agency Case File for the Waiver Participant:</p> <ol style="list-style-type: none"> 1. All provider agencies shall maintain at the administrative office a confidential 			
---	--	--	--

<p>case file for each individual that includes all of the following elements:</p> <ol style="list-style-type: none"> a. Emergency contact information for the following individuals/entities that includes addresses and telephone numbers for each: <ol style="list-style-type: none"> 1. Consumer 2. Primary caregiver 3. Family/relatives, guardians or conservators 4. Significant friends 5. Physician 6. Case Manager 7. Provider agencies 8. Pharmacy b. Individual's health plan, if appropriate c. Individual's current ISP d. Progress notes and other service delivery documentation e. A medical history that shall include at least: demographic data; current and past medical diagnoses including the cause of the medically fragile conditions and developmental disability; medical and psychiatric diagnoses; allergies (food, environment, medications); immunizations; and most recent physical exam. f. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. <p>NMAC 7. 28. Quality Improvement Each agency must establish an on-going quality improvement program to ensure an adequate and effective operation. To be considered on-going, the quality improvement program must document</p>			
--	--	--	--

quarterly activity that addresses, but is not limited to:

39.2 Operational Activities: Assessment of the total operation of the agency, such as, policies and procedures, statistical data (i.e., admissions, discharges, total visits by discipline, etc.), summary of quality improvement activities, summary of patient/client complaints and resolutions, and staff utilization.

NMAC 7.28.2 40 Complaints: The home health agency must investigate complaints made by a patient/client, caregiver, or guardian regarding treatment or care, or regarding the lack of respect for the patient/client's property and must document both the existence of the complaint and the resolution of the complaint.

--	--	--	--

<p>area of developmental disabilities and/or medically fragile conditions is preferred.</p> <ol style="list-style-type: none"> 2. When the HH Agency deems the nursing applicant's experience does not meet MFW Standard, then the applicant can be considered for employment by the agency if he/she completes an approved internship or similar program. The program must be approved by the MFW Manager and the Human Services Department (HSD) representative. 3. The supervision of all HH Agency personnel is the responsibility of the HH Agency Administrator or Director. 4. The HH Agency Nursing Supervisor(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN and Home Health Aide (HHA). 5. The HH Agency staff will be culturally sensitive to the needs and preferences of the participant/participant representative and households. Arrangement of written or spoken communication in another language may need to be considered. 6. The HH Agency will document and report any noncompliance with the ISP to the CM. 7. All Physician/Healthcare Practitioner orders that change the participant's LOC will be conveyed to the CM for coordination with service providers and modification to the ISP/budget if necessary. 8. The HH Agency will document in the participant's clinical file RN supervision to occur at least every sixty (60) days. Supervisory forms must be developed 			
---	--	--	--

<p>and implemented specifically for this task.</p> <p>9. The HH Agency and CM must have documented monthly contact that reflects the discussion and review of services and ongoing coordination of care.</p> <p>10. The HH Agency supervising RN, direct care RN, and LPN shall train the participant, family, direct support professional (DSP) and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments, use of equipment and technologies, or other areas of concern.</p> <p>11. It is expected that the HH Agency will consult with the participant, IDT members, guardians, family and DSP as needed.</p> <p><u>NMAC 7.28.2.37.1.5</u> Health certificate for all staff having contact with patient/clients stating that the employee is free from tuberculosis in a transmissible form as required by the Infectious Disease Bureau, of the Public Health Division, Department of Health.</p>			
--	--	--	--

<p>6. The HHA will be culturally sensitive to the needs and preferences of the participants and their families. Based upon the individual language needs or preferences, HHA may be requested to communicate in a language other than English.</p> <p>C. All supervisory visits/contacts must be documented in the participant's HH Agency clinical file on a standardized form that reflects the following:</p> <ol style="list-style-type: none"> 1. Service received 2. Participant's status 3. Contact with family members 4. Review of HHA plan of care with appropriate modification annually and as needed <p>D. Requirements for the HH Agency Serving Medically Fragile Waiver Population:</p> <ol style="list-style-type: none"> 1. The HH Agency nursing supervisor(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN and HHA. 2. The HH Agency staff will be culturally sensitive to the needs and preferences of participants and households. Arrangements of written or spoken communication in another language may need to be considered. 3. The HH Agency will document and report any noncompliance with the ISP to the case manager. 4. All Physician orders that change the participant's service needs should be conveyed to the CM for coordination with service providers and modification to ISP/MAD 046 if necessary. 5. The HH Agency will document in the participant's clinical file that the RN supervision of the HHA occurs at least once every sixty days. Supervisory forms must be developed and implemented specifically for this task. 			
--	--	--	--

<p>6. The HH Agency and CM must have documented monthly contact that reflects discussion and review of services and ongoing coordination of care.</p> <p>7. The HH Agency supervising RN, direct care RN and LPN shall train families, direct support professionals and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments, use of equipment and technologies or other areas of concern.</p> <p>8. It is expected the HH Agency will consult with Interdisciplinary Team (IDT) members, guardians, family and direct support professionals (DSP) as needed.</p> <p><u>NMAC 7.28.2.37.1.5</u> Health certificate for all staff having contact with patient/clients stating that the employee is free from tuberculosis in a transmissible form as required by the Infectious Disease Bureau, of the Public Health Division, Department of Health.</p> <p><u>NMAC 7.28.2.30.3.1</u> Home Health Aides: The home health aide training program must address each of the subject areas listed below. 30.3.1.H Recognizing emergencies and knowledge of emergency procedures Including CPR and first aid).</p> <p><u>NMAC 7.28.2.30.6</u> Annual In-Service Training: Each home health aide must participate in at least twelve (12) documented hours of in-service training during each twelve (12) month period. This requirement may be fulfilled on a prorated basis during the home health aide's first year of employment at the home health agency.</p>			
--	--	--	--

NMAC 7.28.2.30.7

Annual Performance Review: A performance review, including written evaluation and skills demonstration must be completed on each home health aide no less frequently that every twelve (12) months.

<p>considered as a HHA.</p> <p>G. The HHA is not a primary care giver, therefore when the HHA is on duty, there must be an approved primary caregiver available in person. The participant and/or representative and agency have the responsibility to assure there is a primary caretaker available in person. The primary caregiver must be available on the property where the participant is currently located and within audible range of the participant and HHA.</p> <p>H. All designated primary caretakers' names and phone numbers must be written in the backup plan and agreed upon by the agency and representative. The designated approved back up primary caregiver will not be reimbursed by the MFW/DDSD.</p> <p>I. An emergency backup plan for medical needs and staffing must be developed, written and agreed upon by the HH Agency and participant/participant representative. The emergency backup plan will be available in participant's home. The plan will be modified when medical conditions warrant and will be reviewed at least annually.</p>			
--	--	--	--

<p>Tag # 1A25 Criminal Caregiver History Screening</p>			
<p>NMAC 7.1.9.9 A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</p> <p>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:</p> <p>A. homicide;</p> <p>B. trafficking, or trafficking in controlled substances;</p> <p>C. kidnapping, false imprisonment, aggravated assault or aggravated battery;</p> <p>D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;</p> <p>E. crimes involving adult abuse, neglect or financial exploitation;</p> <p>F. crimes involving child abuse or neglect;</p> <p>G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or</p> <p>H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p> <p>Chapter 1.IV. General Provider Requirements. D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee’s qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.</p>	<p>Based on record review, the Agency failed to maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program on file for 1 of 3 Agency Personnel.</p> <p>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</p> <ul style="list-style-type: none"> • # 41 – Date of hire 10/20/2015. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → </p>	

documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.

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

Chapter 1.IV. General Provider Requirements.

D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

TAG # MF25 Private Duty Nursing – Reimbursement			
<p>New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Waiver (MFW) effective 1/01/2011</p> <p>PRIVATE DUTY NURSING III. REIMBURSEMENT</p> <p>Each provider of a service is responsible for providing clinical documentation that identifies the DSP’s role in all components of the provision of home care: including assessment information, care planning, intervention, communications and care coordination and evaluation. There must be justification in each participant’s medical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of care. Services must be reflected in the ISP that is coordinated with the participant/participant’s representative, other caregivers as applicable, and authorized by the approved budget. All services provided, claimed and billed must have documented justification supporting medical necessity and be covered by the MFW.</p> <ul style="list-style-type: none"> A. Payment for PDN services through the Medicaid waiver is considered payment in full. B. PDN services must abide by all Federal, State and HSD and DOH policies and procedures regarding billable and non-billable items. C. Billed services must not exceed the capped dollar amount for LOC. D. PDN services are a Medicaid benefit for children birth to 21 years, through the children’s EPSDT program. E. The Medicaid benefit is the payer of last 	<p>Billing for Private Duty Nursing Services was reviewed for the months of August, September, and October 2015. Progress notes and other documentation reviewed were sufficient to justify billing for 1 of 1 Individuals.</p>	<p>No Plan of Correction Required</p>	

<p>resort. Payment for the PDN services should not be requested until all other third-party and community resources have been explored and/or exhausted.</p> <p>F. PDN services are a MFW benefit for the 21 year and older enrolled participant. The MFW benefit is the payer of last resort. Payment for waiver services should not be requested or authorized until all other third-party and community resources have been explored and/or exhausted.</p> <p>G. Reimbursement for PDN services will be based on the current rate allowed for services.</p> <p>H. The HH Agency must follow all current billing requirements by the HSD and DOH for PDN services.</p> <p>I. Service providers have the responsibility to review and assure that the information on the MAD 046 form for their services is current. If providers identify an error, they will contact the CM or a supervisor of the case.</p> <ol style="list-style-type: none"> 1. The private duty nurse may ride in the vehicle with the participant for the purpose of oversight, support or monitoring during transportation. The private duty nurse may not operate the vehicle for the purpose of transporting the participant. <p>J. The MFW Program does not consider the following to be professional PDN duties and will not authorize payment for:</p> <ol style="list-style-type: none"> 1. Performing errands for the participant/participant representative or family that is not program specific. 2. "Friendly visiting," meaning visiting with the participant outside of PDN 			
--	--	--	--

<p>work scheduled.</p> <ol style="list-style-type: none"> 3. Financial brokerage services, handling of participant finances or preparation of legal documents. 4. Time spent on paperwork or travel that is administrative for the provider. 5. Transportation of participants. 6. Pick up and/or delivery of commodities. 7. Other non-Medicaid reimbursable activities. 			
--	--	--	--

<p>explored and/or exhausted.</p> <p>F. Reimbursement for HHA services will be based on the current rate allowed for the service.</p> <p>G. The HH Agency must follow all current billing requirements by the HSD and the DOH for HHA services.</p> <p>H. Providers of service have the responsibility to review and assure that the information of the MAD 046 for their services is current. If the provider identifies an error, they will contact the CM or a supervisor at the case management agency immediately to have the error corrected.</p> <ol style="list-style-type: none"> 1. The HHA may ride in the vehicle with the participant for the purpose of oversight during transportation. The HHA will accompany the participant for the purpose of monitoring or support during transportation. This means the HHA may not operate the vehicle for purpose of transporting the participant. <p>I. The MFW Program does not consider the following to be professional HHA duties and will not authorize payment for:</p> <ol style="list-style-type: none"> 1. Performing errands for the participant/participant's representative or family that is not program specific. 2. "Friendly visiting", meaning visits with the participant outside of work scheduled. 3. Financial brokerage services, handling of participant finances or preparation of legal documents. 4. Time spent on paperwork or travel that is administrative for the provider. 5. Transportation of participants. 6. Pick up and/or delivery of commodities. 7. Other non-Medicaid reimbursable activities. 			
--	--	--	--

Date: April 6, 2016

To: David Stong, Director of Finance
Provider: Harmony Home Health Services Limited Liability Company
Address: 5650 S Green Street
State/Zip: Murray, Utah 84123

E-mail Address: davids@harmonyhomehealth.com
jennio@harmonyhomehealth.com

Region: Metro
Survey Date: December 14 - 16, 2015
Program Surveyed: Medically Fragile Waiver

Service Surveyed: Home Health Aide Services (HHAS), Private Duty Nursing (PDN) RN

Survey Type: Routine

Dear Mr. David Stong;

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 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,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.15.1.MF.D0706.3.RTN.09.16.097