



SUSANA MARTINEZ, GOVERNOR

LYNN GALLAGHER, CABINET SECRETARY

REVISED by IRF 12/19/2018

Date: October 17, 2018
To: Janyce Wallace, Executive Director
Provider: Tender Loving Care (TLC) Homes, LLC
Address: 7700 Ranchwood Drive NW
State/Zip: Albuquerque, New Mexico 87120
E-mail Address: cjanya@yaho.com
Region: Metro Region
Survey Date: September 25 - 27, 2018
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: 2018: Supported Living
2012: Supported Living
Survey Type: Initial Survey
Team Leader: Kandis Gomez, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Janyce Wallace;

The Division of Health Improvement/Quality Management Bureau has completed a compliance 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. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Determination of Compliance:

The Division of Health Improvement, Quality Management Bureau has determined your agency is in:

Compliance: This determination is based on your agency's compliance with Condition of Participation level and Standard level requirements. Deficiencies found only affect a small percentage of the Individuals on the survey sample (refer to Attachment D for details). The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

The following tags are identified as Standard Level:

- Tag # 1A08.1 Administrative and Residential Case File: Progress Notes
Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry
Tag # LS26 Supported Living Reimbursement

Plan of Correction:

DIVISION OF HEALTH IMPROVEMENT
5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108
(505) 222-8623 • FAX: (505) 222-8661 • http://www.dhi.health.state.nm.us



QMB Report of Findings – Tender Loving Care (TLC) Homes, LLC – Metro – September 25 – 27, 2018

The attached Report of Findings identifies the deficiencies found during your agency's on-site 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.

You were provided information during the exit meeting portion of your on-site survey. Please refer to this information (Attachment A) for specific instruction on completing your Plan of Correction. At a minimum your Plan of Correction should address the following for each Tag cited:

Corrective Action for Current Citation:

- How is the deficiency going to be corrected? (i.e. obtained documents, retrain staff, individuals and/or staff no longer in service, void/adjusts completed, etc.) This can be specific to each deficiency cited or if possible an overall correction, i.e. all documents will be requested and filed as appropriate.

On-going Quality Assurance/Quality Improvement Processes:

- What is going to be done on an ongoing basis? (i.e. file reviews, etc.)
- How many individuals is this going to effect? (i.e. percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e. weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position within your agency)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORA, etc.)
- How is this integrated in your agency's QIS, QI Committee reviews and annual report?

Submission of your Plan of Correction:

Please submit your agency's Plan of Correction in the available space on the two right-hand 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: Amanda Castaneda, Plan of Correction Coordinator
1170 North Solano Suite D Las Cruces, New Mexico 88001**
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.

Billing Deficiencies:

If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a "Void/Adjust" claim or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: Lisa Medina-Lujan
HSD/OIG
Program Integrity Unit
2025 S. Pacheco Street
Santa Fe, New Mexico 87505

Or if using UPS, FedEx, DHL (courier mail) send to physical address at:

Attention: Lisa Medina-Lujan
HSD/OIG
Program Integrity Unit
1474 Rodeo Road
Santa Fe, New Mexico 87505

Please be advised that there is a one-week lag period for applying payments received by check to Void/Adjust claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.

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:

Request for Informal Reconsideration of Findings
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,

Kandis Gomez, AA

Kandis Gomez, AA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

On-site Entrance Conference Date: September 25, 2018

Present: **Tender Loving Care (TLC) Homes, LLC**
Janyce Wallace, Executive Director/Owner
Porschia Sherman, Service Coordinator/Program Director
JoAnne Moreland, Administrative Assistant

DOH/DHI/QMB

Kandis Gomez, AA, Team Lead/Healthcare Surveyor
Lora Norby, Healthcare Surveyor

Exit Conference Date: September 27, 2018

Present: **Tender Loving Care (TLC) Homes, LLC**
Janyce Wallace, Executive Director/Owner
Porschia Sherman, Service Coordinator/Program Director
Barbara Beaudette, Registered Nurse

DOH/DHI/QMB

Kandis Gomez, AA, Team Lead/Healthcare Surveyor
Lora Norby, Healthcare Surveyor

DDSD Metro Regional Office

Larry Lovato, Social and Community Service Coordinator
Steve Moyers, Social and Community Service Coordinator

Administrative Locations Visited 1

Total Sample Size 2

0 - Jackson Class Members
2 - Non-Jackson Class Members

2 - Supported Living

Total Homes Visited 1

❖ Supported Living Homes Visited 2

Note: The following Individuals share a SL residence:

➤ #1, 2

Persons Served Records Reviewed 2

Persons Served Interviewed 2

Direct Support Personnel Interviewed 1

Direct Support Personnel Records Reviewed 3 (One Service Coordinator performs dual roles as a DSP)

Service Coordinator Records Reviewed 1 (One Service Coordinator performs dual roles as a DSP)

Administrative Interviews 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 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 DDSD Regional Office for purposes of contract management or 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 DDSD 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 cited to prevent recurrence and information that ensures the regulation cited comes into and remains in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance (QA) Plan.

If a deficiency has already been corrected since the on-site survey, 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 following details should be considered when developing your Plan of Correction:

The Plan of Correction must address each deficiency cited in the Report of Findings unless otherwise noted with a "No Plan of Correction Required statement." The Plan of Correction must address the five (5) areas listed below:

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 those individuals in similar situations.
3. What Quality Assurance measures will be put into place and what systemic changes made to ensure the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make certain solutions are sustained. The agency must develop a QA plan for ensuring correction is achieved and sustained. This QA plan must be implemented and the corrective action is evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State.

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

- Details about how and when Individual Served, agency personnel and administrative and service delivery site 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 to service sites, as they are being used, and after they are completed;
- Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management providers, how Individual Service Plans are reviewed to verify they meet requirements, how the timeliness of level of care (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 must 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 Castaneda at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda 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 North Solano Ste D, Las Cruces, New Mexico 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 documents containing HIPAA Protected Health Information (PHI) documents must be submitted through S-Comm (Therap), Fax or Postal System, do not send PHI directly to NMDOH email accounts. If the documents do not contain protected Health information (PHI) then you may 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 DDS 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.

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 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
- **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 Documentation - Nurse Availability
- **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 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: <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, 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.

Attachment D

QMB Determinations of Compliance

Compliance:

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or has no deficiencies at the Condition of Participation Level. 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 Standard Level Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any 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	
Standard Level 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 Standard Level Tags with 75 to 100% of the Individuals in the sample cited in any 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 of 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.					

<p>settings.</p> <p>4. 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>5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</p> <p>6. 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.</p> <p>7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p>Chapter 6 (CCS) 3. Agency Requirements: 4. Reimbursement A. Record Requirements 1. ...Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record...</p> <p>Chapter 7 (CIHS) 3. Agency Requirements: 4. Reimbursement A. 1....Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record...</p>			
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Chapter 11 (FL) 3. Agency Requirements: 4. Reimbursement A. 1....Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record...

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
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.			
Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	Standard Level Deficiency		
<p>NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying</p>	<p>Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 1 of 3 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:</p> <p>Direct Support Personnel (DSP):</p> <ul style="list-style-type: none"> • #500 – Date of hire 7/12/2018, completed 7/23/2018. 	<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>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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): → </p>	<p> </p>

information required by the registry.

D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the 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.

F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
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.			
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up (Removed by IRF)	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</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> <p>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:</p> <p>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;</p> <p>b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have 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</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 provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 1 of 2 individuals receiving Living Care Arrangements.</p> <p>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p>Auditory Exam:</p> <ul style="list-style-type: none"> Individual #1 - As indicated by collateral documentation reviewed, exam was completed on 1/7/2016. Follow-up was to be completed in 2 years. No evidence of follow-up found. (Note: Exam scheduled for 10/9/2018) <p><i>Note: Auditory Exam for Individual #1 removed by IRF 12/19/2018.</i></p>	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (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?): →</p>	

<p>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> <ul style="list-style-type: none"> a. 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. b. 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. c. Providers support the person/guardian to make an informed decision. 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>Chapter 20: Provider Documentation and Client Records:</p> <p>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. DD Waiver Provider Agencies are required to</p>			
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adhere to the following:

1. 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.
2. 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.
3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.
4. 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.
5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.
6. 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.
7. 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.

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. The Physician Consultation form contains a list of all current medications.

**Chapter 10: Living Care Arrangements (LCA)
Living Supports-Supported Living: 10.3.9.6.1
Monitoring and Supervision**

4. Ensure and document the following:
 - a. The person has a Primary Care Practitioner.
 - b. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist.
 - c. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist.
 - d. The person receives a hearing test as recommended by a licensed audiologist.
 - e. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist.
5. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine).

**10.3.10.1 Living Care Arrangements (LCA)
Living Supports-IMLS:**

10.3.10.2 General Requirements: 9 . Medical services must be ensured (i.e., ensure each person has a licensed Primary Care Practitioner and receives an annual physical examination, specialty medical care as needed, and annual

dental checkup by a licensed dentist).

Chapter 13 Nursing Services: 13.2.3 General Requirements:

1. Each person has a licensed primary care practitioner and receives an annual physical examination and specialty medical/dental care as needed. Nurses communicate with these providers to share current health information.

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015

Chapter 6 (CCS) 3. Agency Requirements:

G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 7 (CIHS) 3. Agency Requirements:

E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 11 (FL) 3. Agency Requirements:

D. Consumer Records Policy: All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012

III. Requirement Amendments(s) or

Clarifications:

A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.

H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
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.			
Tag # LS26 Supported Living Reimbursement (Modified by IRF)	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p>Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements: DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following:</p> <ol style="list-style-type: none"> 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: <ol style="list-style-type: none"> a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and h. the nature of services. 3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer. 	<p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 2 of 2 individuals.</p> <p>Individual #1 July 2018</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/14/2018. Documentation did not contain the required elements on 7/14/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 7/14/2018 upheld by IRF.</i></p> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/15/2018. Documentation did not contain the required elements on 7/15/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 7/15/2018 upheld by IRF.</i></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>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>4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:</p> <ol style="list-style-type: none"> treatment or care of any eligible recipient; services or goods provided to any eligible recipient; amounts paid by MAD on behalf of any eligible recipient; and any records required by MAD for the administration of Medicaid. <p>21.9 Billable Units: The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units.</p> <p>21.9.1 Requirements for Daily Units: For services billed in daily units, Provider Agencies must adhere to the following:</p> <ol style="list-style-type: none"> A day is considered 24 hours from midnight to midnight. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months. When a person transitions from one Provider Agency to another during the ISP year, a standard formula to calculate the units billed by each Provider Agency must be applied as follows: <ol style="list-style-type: none"> The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%). The receiving Provider Agency bills the remaining days up to 340 for the ISP year. <p>21.9.2 Requirements for Monthly Units: For services billed in monthly units, a Provider</p>	<ul style="list-style-type: none"> The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/16/2018. Documentation did not contain the required elements on 7/16/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 7/16/2018 upheld by IRF.</i></p> The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/23/2018. Documentation did not contain the required elements on 7/23/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 7/23/2018 upheld by IRF.</i></p> The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/24/2018. Documentation did not contain the required elements on 7/24/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 7/24/2018 upheld by IRF.</i></p> The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/25/2018. Documentation did not contain the required elements on 7/25/2018. Documentation received accounted for .5 units. 		
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<p>Agency must adhere to the following:</p> <ol style="list-style-type: none"> 1. A month is considered a period of 30 calendar days. 2. At least one hour of face-to-face billable services shall be provided during a calendar month where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. 4. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit. <p>21.9.3 Requirements for 15-minute and hourly units: For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following:</p> <ol style="list-style-type: none"> 1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2. 2. Services that last in their entirety less than eight minutes cannot be billed. 	<p><i>Note: Billing deficiency on 7/25/2018 modified by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/26/2018. Documentation did not contain the required elements on 7/26/2018. Documentation received accounted for .5 units. <p><i>Note: Billing deficiency on 7/26/2018 modified by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/27/2018. Documentation did not contain the required elements on 7/27/2018. Documentation received accounted for .5 units. <p><i>Note: Billing deficiency on 7/27/2018 modified by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/30/2018. Documentation did not contain the required elements on 7/30/2018. Documentation received accounted for .5 units. <p><i>Note: Billing deficiency on 7/30/2018 modified by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/31/2018. Documentation did not contain the required elements on 7/31/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➢ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 7/31/2018 upheld by IRF.</i></p> <p>August 2018</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/1/2018. 		
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	<p>Documentation did not contain the required elements on 8/1/2018. Documentation received accounted for .5 units. <i>Note: Billing deficiency on 8/1/2018 modified by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/2/2018. Documentation did not contain the required elements on 8/2/2018. Documentation received accounted for .5 units. <i>Note: Billing deficiency on 8/2/2018 modified by IRF.</i> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/3/2018. Documentation did not contain the required elements on 8/3/2018. Documentation received accounted for .5 units. <i>Note: Billing deficiency on 8/3/2018 modified by IRF.</i> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/5/2018. Documentation did not contain the required elements on 8/5/2018. Documentation received accounted for .5 units. <i>Note: Billing deficiency on 8/5/2018 modified by IRF.</i> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/6/2018. Documentation did not contain the required elements on 8/6/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <i>Note: Billing deficiency on 8/6/2018 upheld by IRF.</i> 		
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	<ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/7/2018. Documentation did not contain the required elements on 8/7/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 8/7/2018 upheld by IRF.</i></p> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/8/2018. Documentation did not contain the required elements on 8/8/2018. Documentation received accounted for .5 units. <p><i>Note: Billing deficiency on 8/8/2018 modified by IRF.</i></p> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/9/2018. Documentation did not contain the required elements on 8/9/2018. Documentation received accounted for .5 units. <p><i>Note: Billing deficiency on 8/9/2018 modified by IRF.</i></p> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/10/2018. Documentation did not contain the required elements on 8/10/2018. Documentation received accounted for .5 units. <p><i>Note: Billing deficiency on 8/10/2018 modified by IRF.</i></p> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/13/2018. Documentation did not contain the required elements on 8/13/2018. Documentation received accounted for .5 units. 		
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	<p><i>Note: Billing deficiency on 8/13/2018 modified by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/15/2018. Documentation did not contain the required elements on 8/15/2018. Documentation received accounted for .5 units. <p><i>Note: Billing deficiency on 8/15/2018 modified by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/16/2018. Documentation did not contain the required elements on 8/16/2018. Documentation received accounted for .5 units. <p><i>Note: Billing deficiency on 8/16/2018 modified by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/17/2018. Documentation did not contain the required elements on 8/17/2018. Documentation received accounted for .5 units. <p><i>Note: Billing deficiency on 8/17/2018 modified by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/18/2018. Documentation did not contain the required elements on 8/18/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 8/18/2018 removed by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/19/2018. Documentation did not contain the required 		
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	<p>elements on 8/19/2018. Documentation received accounted for 0 units. The required element was not met:</p> <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 8/18/2018 removed by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/20/2018. Documentation did not contain the required elements on 8/20/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 8/18/2018 removed by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/21/2018. Documentation did not contain the required elements on 8/21/2018. Documentation received accounted for .5 units. <p><i>Note: Billing deficiency on 8/21/2018 modified by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/22/2018. Documentation did not contain the required elements on 8/22/2018. Documentation received accounted for .5 units. <p><i>Note: Billing deficiency on 8/22/2018 modified by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/31/2018. Documentation did not contain the required elements on 8/31/2018. Documentation 		
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	<p>received accounted for 0 units. The required element was not met:</p> <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 8/31/2018 upheld by IRF.</i></p> <p>Individual #2 July 2018</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/16/2018. Documentation received accounted for .5 units. <p><i>Note: Billing deficiency on 7/16/2018 modified by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/17/2018. Documentation did not contain the required elements on 7/17/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 7/17/2018 upheld by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/18/2018. No documentation was found for 7/18/2018 to justify the 1 unit. <p><i>Note: Billing deficiency on 7/18/2018 upheld by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/19/2018. No documentation was found for 7/19/2018 to justify the 1 unit. <p><i>Note: Billing deficiency on 7/19/2018 upheld by IRF.</i></p>		
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	<ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/20/2018. Documentation did not contain the required elements on 7/20/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 7/20/2018 upheld by IRF.</i></p> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/23/2018. Documentation did not contain the required elements on 7/23/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 7/23/2018 upheld by IRF.</i></p> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/24/2018. Documentation did not contain the required elements on 7/24/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 7/24/2018 upheld by IRF.</i></p> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/25/2018. Documentation did not contain the required elements on 7/25/2018. Documentation 		
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	<p>received accounted for 0 units. The required element was not met:</p> <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 7/25/2018 upheld by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/29/2018. Documentation did not contain the required elements on 7/29/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 7/29/2018 removed by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/30/2018. No documentation was found for 7/30/2018 to justify the 1 unit. <p><i>Note: Billing deficiency on 7/30/2018 upheld by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/31/2018. Documentation did not contain the required elements on 7/31/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 7/31/2018 upheld by IRF.</i></p> <p>August 2018</p>		
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	<ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 8/1/2018. Documentation received accounted for .5 units. <i>Note: Billing deficiency on 8/1/2018 modified by IRF.</i> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 8/2/2018. Documentation received accounted for .5 units. <i>Note: Billing deficiency on 8/2/2018 modified by IRF.</i> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 8/3/2018. Documentation received accounted for .5 units. <i>Note: Billing deficiency on 8/3/2018 modified by IRF.</i> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 8/6/2018. Documentation did not contain the required elements on 8/6/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <i>Note: Billing deficiency on 8/6/2018 upheld by IRF.</i> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 8/7/2018. Documentation did not contain the required elements on 8/7/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <i>Note: Billing deficiency on 8/6/2018 upheld by IRF.</i> 		
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	<ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 8/8/2018. Documentation received accounted for .5 units. <i>Note: Billing deficiency on 8/8/2018 modified by IRF.</i> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 8/9/2018. Documentation received accounted for .5 units. <i>Note: Billing deficiency on 8/9/2018 modified by IRF.</i> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 8/10/2018. Documentation received accounted for .5 units. <i>Note: Billing deficiency on 8/10/2018 modified by IRF.</i> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 8/14/2018. Documentation received accounted for .5 units. <i>Note: Billing deficiency on 8/14/2018 modified by IRF.</i> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 8/19/2018. Documentation did not contain the required elements on 8/19/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <i>Note: Billing deficiency on 8/19/2018 removed by IRF.</i> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 8/21/2018. Documentation did not contain the required elements on 8/21/2018. Documentation 		
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	<p>received accounted for 0 units. The required element was not met:</p> <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 8/21/2018 upheld by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 8/22/2018. Documentation did not contain the required elements on 8/22/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 8/22/2018 upheld by IRF.</i></p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 8/23/2018. Documentation did not contain the required elements on 8/23/2018. Documentation received accounted for 0 units. The required element was not met: <ul style="list-style-type: none"> ➤ Start and end time of each service encounter or other billable service interval; <p><i>Note: Billing deficiency on 8/23/2018 upheld by IRF.</i></p>		
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REVISED 12/19/2018

Date: December 18, 2018

To: Janyce Wallace, Executive Director
Provider: Tender Loving Care (TLC) Homes, LLC
Address: 7700 Ranchwood Drive NW
State/Zip: Albuquerque, New Mexico 87120

E-mail Address: cjanyce@yahoo.com

Region: Metro Region
Survey Date: September 25 - 27, 2018
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2018:** Supported Living
2012: Supported Living

Survey Type: Initial Survey

RE: Request for an Informal Reconsideration of Findings

Dear Ms. Wallace,

Your request for a Reconsideration of Findings was received on October 31, 2018. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag #1A08.2

Determination: The IRF committee is removing the original finding in the report of findings. Based on physician paperwork provided during the IRF process, the Auditory Exam for Individual #1 was due within 3 years not 2 years as indicated on the Physician Consultation Form filled out by the agency. Based on the official paperwork, this finding will be removed. Since this was the only citation in Tag 1A08.2, the tag will also be removed which will result in a change in compliance determination from a Partial Compliance to a Compliance.

Regarding Tag #LS26

Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the documentation provided, the billing deficiencies which are being modified, removed or upheld are as follows:

- Individual #1
 - Billing deficiencies for 7/14, 15, 16, 23, 24, 31 and 8/6, 7 and 31 will be upheld as the documentation provided did not contain all required elements for billing.

- Billing deficiencies for 7/25, 26, 27, 30 and 8/1, 2, 3, 5, 8, 9, 10, 13, 15, 16, 17, 21 and 22 will be modified as documentation provided justified ½ a unit (.5) being billed on those days.
- Billing deficiencies for 8/18, 19 and 20 will be removed as documentation provided justified 1 unit billed.
- Individual #2
 - Billing deficiencies for 7/17, 18, 19, 20, 23, 24, 25, 30, 31 and 8/6, 7, 21, 22 and 23 will be upheld as the documentation provided did not contain all required elements for billing.
 - Billing deficiencies for 7/16 and 8/1, 2, 3, 8, 9, 10, and 14 will be modified as documentation provided justified ½ a unit (.5) being billed on those days.
 - Billing deficiencies for 7/29 and 8/19 will be removed as documentation provided justified 1 unit billed.

This concludes the Informal Reconsideration of Finding process. The IRF process is separate and apart from the Informal Dispute Resolution process or the Medicaid Fair Hearing process when DOH sanctions are imposed on a provider.

Thank you.
Respectfully,

Crystal Lopez-Beck

Crystal Lopez-Beck
Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair

Q.19.2.DDW.55388515.5.INT.12.18.352

Date: December 28, 2018

To: Janyce Wallace, Executive Director
Provider: Tender Loving Care (TLC) Homes, LLC
Address: 7700 Ranchwood Drive NW
State/Zip: Albuquerque, New Mexico 87120

E-mail Address: cjanyce@yahoo.com

Region: Metro Region
Survey Date: September 25 - 27, 2018
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2018:** Supported Living
2012: Supported Living

Survey Type: Initial Survey

Dear Ms. Janyce Wallace;

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,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI