Date: December 9, 2020

To: Judy M. Sanchez, MBA, Administrator
Provider: Children's Home Healthcare, Inc. (DJK Home Healthcare, LLC)
Address: 4600 A. Montgomery Blvd. NE Ste. A-101
State/Zip: Albuquerque, New Mexico 87109

E-mail Address: judy@childrenshha.com

CC: Kara Gaut, RN, Board of Directors Chairperson
E-Mail Address kara@childrenshha.com

Region: Metro and Northeast
Survey Date: November 9 - 19, 2020
Program Surveyed: Medically Fragile Waiver (MFW)

Service Surveyed: Respite Private Duty Nursing (PDN)

Survey Type: Routine

Team Leader: Yolanda J. Herrera, RN, Nurse Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Monica Valdez, BS, Plan of Correction Coordinator and Healthcare Surveyor Advanced, Division of Health Improvement/Quality Management Bureau and Iris Clevenger, BSN, RN, CCM, MA, MFW Program Manager, Developmental Disabilities Supports Division

Dear Ms. J. Sanchez:

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 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.

The attached QMB Report of Findings indicates deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as deficiencies:

- Tag # MF05 Documentation Requirements – Agency Case Files
- Tag # MF22 Private Duty Nursing – Scope of Services – Plans / Assessments
- Tag # MF23 Private Duty Nursing – Agency/Individual Requirements

Plan of Correction:

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: Monica Valdez, Plan of Correction Coordinator 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108**

2. **Developmental Disabilities Supports Division, Attention: Medically Fragile Waiver Program Manager**

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

1474 Rodeo Road
Santa Fe, New Mexico 87505

If you have questions and would like to speak with someone at HSD/OIG/PIU, please contact:

*Lisa Medina-Lujan (*Lisa.medina-lujan@state.nm.us*)*

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:

ATTN: QMB Bureau Chief
Request for Informal Reconsideration of Findings
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request/QMB

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, Monica Valdez at 505-273-1930 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,

Yolanda J. Herrera, RN

Yolanda J. Herrera, RN
Nurse Healthcare Surveyor / Team Lead
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	November 9, 2020
Contact:	**Children's Home Healthcare, Inc. (DJK Home Healthcare, LLC)** Judy M. Sanchez, MBA, Administrator **DOH/DHI/QMB** Yolanda J. Herrera, RN, Nurse Healthcare Surveyor / Team Lead
Entrance Date:	November 9, 2020
Present:	**Children's Home Healthcare, Inc. (DJK Home Healthcare, LLC)** Judy M. Sanchez, MBA, Administrator Jenny Gallant, RN, Clinical Supervisor **DOH/DHI/QMB** Yolanda J. Herrera, RN, Nurse Healthcare Surveyor / Team Lead Monica Valdez, BS, Plan of Correction Coordinator, Healthcare Surveyor Advanced
Exit Date:	November 19, 2020
Present:	**Children's Home Healthcare, Inc. (DJK Home Healthcare, LLC)** Judy M. Sanchez, MBA, Administrator Jenny Gallant, RN, Clinical Supervisor **DOH/DHI/QMB** Yolanda J. Herrera, RN, Nurse Healthcare Surveyor / Team Lead Monica Valdez, BS, Plan of Correction Coordinator / Healthcare Surveyor Advanced **DDSD – Clinical Services Bureau** Iris Clevenger, RN, BSN, MA, CCM, MFW Program Manager
Administrative Locations Visited	Number: 0 *(Note: No administrative locations visited due to COVID-19 Pandemic Public Health Emergency)*
Total Sample Size:	3 3 – Respite Private Duty Nursing (PDN)
Total Homes Visited:	0 *(Note: No home visits conducted due to COVID-19 Pandemic Public Health Emergency)*
Persons Served Records Reviewed:	3
Recipient/Family Members Interviewed:	3 *(Note: Interviews conducted by video / phone due to COVID- 19 Public Health Emergency)*
Private Duty Nursing (PDN) Records Reviewed:	4
Private Duty Nursing (PDN) Interviewed:	3 *(Note: Interviews conducted by video / phone due to COVID- 19 Public Health Emergency)*
RN Supervisor Record Reviewed:	1

Administrative Personnel Interviewed: 2 *(1 Administrative Personnel interviewed also provides services as the RN Supervisor)*

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Agency Case Files
- Internal Incident Management System Process and Reports
- Personnel Files – including nursing and subcontracted staff
- Staff Training Records, including staff training hours, competency and interviews with staff
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Cardiopulmonary Resuscitation (CPR) and First Aid for HHAs
- Licensure/Certification for Nursing
- Agency Policies and Procedures Manual
- Quality Assurance / Quality 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 505-273-1930 or email at MonicaE.Valdez@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, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@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 Monica Valdez, POC Coordinator in any of the following ways:
    a. Electronically at MonicaE.Valdez@state.nm.us ***(preferred method)***
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108
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 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.

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

The following limitations apply to the IRF process:

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

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

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

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

Agency/Region(s): **Children's Home Healthcare, Inc. (DJK Home Healthcare, LLC) / Metro and Northeast**
Program: Medically Fragile Waiver
Service(s): Respite Private Duty Nursing (PDN)
Survey Type: Routine
Survey Dates: **November 9 - 19, 2020**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Record Requirements:			
TAG # MF05 Documentation Requirements – Agency Case Files			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **V. PROVIDER AGENCY CASE FILE FOR THE WAIVER PARTICIPANT** All provider agencies are required to maintain at the administrative office a confidential case file for each person that includes all the following elements: a. Emergency contact information for the following individuals/entities that includes addresses and telephone numbers for each: i. Consumer ii. Primary caregiver iii. Family/relatives, guardians or conservators iv. Significant friends v. Physician vi. Case manager vii. Provider agencies viii. 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 which includes at least: demographic data; current and past medical	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 3 of 3 individuals. **Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current for the following:** **Emergency Contact Information:** • Did not contain any Significant Friends Information (#1, 2, 3) • Did not contain complete Physician Information (#1, 2, 3) • Did not contain complete Pharmacy Information (#1, 3) **Medical History Information** • Did not contain Recent Physical Exam (#1, 2, 3)	**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?)*: → **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?)*: →	

diagnoses including the cause of the medically fragile conditions and developmental disability; medical and psychiatric diagnoses; allergies (food, environmental, medications); immunizations; and most recent physical exam. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. **VI. DOCUMENTATION** A. Provider agencies must maintain all records necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to individuals who are currently receiving services. The provider agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, level of services, and length of service billed. B. The documentation of the billable time spent with an individual are kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record must contain at least the following information: a. date and start and end time of each service encounter or other billable service interval; b. description of what occurred during the encounter or service interval; and c. signature and title of staff providing the service verifying that the service and time are correct. C. All records pertaining to services provided to an individual must be maintained for at least six (6) years from the date of creation. D. Verified electronic signatures may be used. An electronic signature must be HIPAA compliant, which means the attribute affixed to an electronic document must bind to a			

particular party. An electronic signature secures the user authentication, proof of claimed identity, at the time the signature is generated. It also creates the logical manifestation of signature, including the possibility for multiple parties to sign a document and have the order of application recognized and proven. In addition, it supplies additional information such as time stamp and signature purpose specific to that user and ensures the integrity of the signed document to enable transportability of data, independent verifiability and continuity of signature capability. If an entity uses electronic signatures, the signature method must assure that the signature is attributable to a specific person and binding of the signature with each particular document. **HOME HEALTH AIDE (HHA)** **IV. REIMBURSEMENT** Each provider of a service is responsible for providing clinical documentation that identifies direct care professional (DCP) roles 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 clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant's representative and other caregivers as applicable. All services provided, claimed and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget.			

A. Payment for HHA services through the Medicaid Waiver is considered payment in full. B. The HHA services must abide by all Federal, State, HSD and DOH policies and procedures regarding billable and non-billable items. C. The billed services must not exceed capped dollar amount for LOC. D. The HHA 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 resort. Payment for HHA services should not be requested until all other third party and community resources have been explored and/or exhausted. F. Reimbursement for HHA services will be based on the current rate allowed for the services. G. The HH Agency must follow all current billing requirements by the HSD and the DOH for HHA services. H. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC. I. Providers of service have the responsibility to review and assure that the information on 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. J. The MFW Program does not consider the following to be professional HHA duties and will not authorize payment for: 1. Performing errands for the participant/participant's representative or family that is not program specific; 2. "Friendly visiting", meaning visits with 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 without agency approval; 6. Pick up and/or delivery of commodities; and 7. Other non-Medicaid reimbursable activities. **<u>RESPITE STANDARDS:</u> II. IN-HOME RESPITE** B. Agency Provider Requirement 1. The agency is responsible to ensure that the direct support professionals (RN, LPN, and HHA) meet all applicable MFW, State and Federal requirements for PDN and HHA. 2. The agency will follow the MFW PDN and HHA Standards. 3. Respite services must be provided by qualified personnel as delineated in the agency's licensure requirements and follow the MFW Standards and the MFW Provider Agreement. 4. Advance notice to the CM is required. This includes a timeline from the person/person's representative. 5. A log of respite hours used must be established and maintained. 6. The CM must complete and approve required paperwork for the agency's respite services prior to implementation. 7. All services provided during respite must be documented following the documentation standards by the MFW, State, Federal and agency requirements. 8. The agency personnel must be culturally sensitive to the needs and preferences of person and members of their household. Arrangement of written or spoken			

communication in another language may need to be considered. **NMAC 8.314.3.17 Reimbursement:** Waiver service providers must submit claims for reimbursement to MAD's fiscal contractor for processing. Claims must be filed per the billing instructions in the medicaid policy manual. Providers must follow all medicaid billing instructions. See Section 8.302.2 NMAC. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to providers of medicaid waiver services is made at a predetermined reimbursement rate. [8.314.3.17 NMAC - Rp, 8 .314.3.17 NMAC, 3/1/2018] **NMAC 7.28.2.34 PATIENT/CLIENT RECORDS:** Each agency licensed pursuant to these regulations must maintain the original record for each patient/client receiving services. Patient/client records shall be made available for review upon request of the licensing authority. Every record must be accurate, legible, promptly completed and consistently organized. A patient/client record must meet the following criteria: A. Content of patient/client record: (1) Medically directed patient/client record must include: (a) past and current medical findings in accordance with accepted professional standard; (b) plan of care; (c) identifying information; (d) name of physician; (e) medications, diet, treatment/services, and activity orders; (f) signed and dated notes on the day service(s) provided;			

(g) copies of summary reports sent to the physician; (h) evidence of patient/client being informed of rights; (i) evidence of coordination of care provided by all personnel providing patient/client services; (j) discharge summary. (2) Non-medically directed patient/client records must include: (a) plan of care; (b) identifying information; (c) signed and dated notes on the day service(s) provided; (d) evidence of patient/client being informed of rights; (e) evidence of coordination of care of all personnel providing patient/client services; (f) evidence of discharge.			

TAG # MF22 Private Duty Nursing – Scope of Services – Plans / Assessments			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **PRIVATE DUTY NURSING** **I. SCOPE OF SERVICE** A. Initiation of PDN Services: When a PDN service is identified as a recommended service, the CM will provide the participant/participant's representative with a Secondary Freedom of Choice (SFOC) form from which the participant/participant's representative selects a Home Health (HH) Agency. Working with the HH Agency and participant/participant's representative, the CM will facilitate the selection of a RN or LPN employed by the chosen agency. The identified agency will obtain a referral/prescription from the Primary Care Provider (PCP) for PDN services. This referral/prescription will be in accordance with Federal and State regulations for licensed HH Agencies. This must be obtained before initiation of treatment. A copy of the written referral will be maintained in the participant's file at the HH Agency. The CM is responsible for including recommended units/hours of services on the MAD 046 form. It is the responsibility of the participant/participant's representative, HH Agency and CM to assure that units/hours of therapy do not exceed the capped dollar amount determined for the participant's LOC and ISP cycle. Strategies, support plans, goals, and outcomes will be developed based on the identified strengths, concerns, priorities, and outcomes in the ISP.	Based on record review, the Agency did not maintain complete documentation of the HH Agency's RN Supervisor or RN designee nursing scope of services for 3 of 3 Individuals served. **Review of the Agency's Individual case files revealed the following items were not found, incomplete, and/or not current:** **CMS-485 not reviewed by RN Supervisor or RN designee at least every 60 days as required for the following:** • Individual #1 – No evidence of RN Supervisor or RN designee review of CMS-485 for: 3/2020. • Individual #2 – No evidence of RN Supervisor or RN designee review of CMS-485 for: 10/2020. **Medication Profiles not reviewed by RN Supervisor or RN designee at least every 60 days as required for the following:** • Individual #1 – No evidence of RN Supervisor or RN designee review for: 3/2020. • Individual #2 – No evidence of RN Supervisor or RN designee review for: 10/2020. • Individual #3 – No evidence of RN Supervisor or RN designee review for: 3/2020.	**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?)*: → **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?)*: →	

B. Private Duty Nursing Services Include: 1. The private duty nurse provides nursing services in accordance with the New Mexico Nursing Practice Act, Chapter 61, and Article 3 NMSA 1978. 2. The private duty nurse develops, implements, evaluates and coordinates the medically fragile participant's plan of care on a continuing basis. This plan of care may require coordination with multiple agencies. A copy of the plan of care must be maintained in the participant's home. 3. The private duty nurse provides the participant, caregiver, and family all training and education pertinent to the treatment plan and equipment used by the participant. 4. The private duty nurse must meet the documentation requirements of the MFW, Federal and State HH Agency licensing regulations and all policies and procedures of the HH Agency where the nurse is employed. All documentation must include dates and types of treatments performed; as well as person's response to treatment and progress towards all goals. 5. The private duty nurse must follow the National HH Agency regulations (42 CFR 484) and state HH Agency licensing regulation (7.28.2 NMAC) that apply to PDN services. 6. The private duty nurse implements the Physician/Healthcare Practitioner orders. 7. The standardized CMS-485 (Home Health Certification and Plan of Care) form will be reviewed by the RN supervisor or RN designee and renewed by the PCP at least every sixty (60) days. 8. The private duty nurse administers Physician/Healthcare Practitioner ordered medication as prescribed utilizing all Federal, State, and MFW regulations and following HH Agency policies and procedures. This includes			

all ordered medication routes including oral, infusion, therapy, subcutaneous, intramuscular, feeding tubes, sublingual, topical, and inhalation therapy. 9. Medication profiles must be maintained for each participant with the original kept at the HH Agency and a copy in the home. The medication profile will be reviewed by the licensed HH Agency RN supervisor or RN designee at least every sixty (60) days. 10. The private duty nurse is responsible for checking and knowing the following regarding medications: a. Medication changes, discontinued medication, and new medication, and will communicate changes to all pertinent providers, primary care giver and family; b. Response to medication; c. Reason for medication; d. Adverse reactions; e. Significant side effects; f. Drug allergies; and g. Contraindications 11. The private duty nurse must follow the HH Agency's policy and procedure for management of medication errors. 12. The private duty nurse providing direct care to a medically fragile participant will be oriented to the unique needs of the participant by the family, HH Agency and other resources as needed, prior to the nurse providing independent services. 13. The private duty nurse develops and maintains skills to safely manage all devices and equipment needed in providing care for the participant. 14. The private duty nurse monitors all equipment for safe functioning and facilitates maintenance and repair as needed.			

15. The private duty nurse will obtain pertinent medical history. 16. The private duty nurse will be responsible for the following: a. Obtaining pertinent medical history; b. Assisting in the development and implementation of bowel and bladder regimens and monitor such regimens and modify as needed. This includes removal of fecal impactions and bowel and/or bladder training, urinary catheter and supra-public catheter care; c. Assisting with the development, implementation, modification, and monitoring of nutritional needs via feeding tubes and orally per Physician/Healthcare Practitioner order and within the nursing scope of practice; d. Providing ostomy care per Physician/Healthcare Practitioner order; e. Monitoring respiratory status and treatments including the participant's response to therapy; f. Providing rehabilitative nursing; g. Collecting specimens and obtaining cultures per Physician/Healthcare Practitioner order; h. Providing routine assessment, implementation, modification, and monitoring of skin condition and wounds; i. Providing routine assessment, implementation, modification, and monitoring of Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL); j. Monitoring vital signs per Physician/Healthcare Practitioner orders or per HH Agency policy. 17. The private duty nurse must consult and collaborate with the participant's PCP, specialists, other team members, and primary care giver/family, for the purpose of evaluation of the participant and/or developing, modifying,			

or monitoring services and treatment. This collaboration with team members will include, but will not be limited to, the following: a. Analyzing and interpreting the person's needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings; b. Identifying short and long-terms goals that are measurable and objective. The goals should include interventions to achieve and promote health that is related to the participant's needs. 18. The individualized service goals and a nursing care plan will be separate from the CMS-485. The nursing plan of care is based on the Physician/Healthcare Practitioner treatment plan and the medically fragile participant's and family's concerns and priorities as identified in the ISP. The identified goals and outcomes in the ISP will be specifically addressed in the nursing plan of care. 19. The private duty nurse must review Physician/Healthcare Practitioner orders for treatment. If changes in the treatment require revisions to the ISP, the agency nurse will contact the CM to request an Interdisciplinary Team (IDT) meeting. 20. The private duty nurse coordinates with the CM all services that may be provided in the home and community setting. 21. PDN services may be provided in the home or other community setting. 22. The private duty nurse may ride in the vehicle with the person 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.			

RESPITE STANDARDS **II. IN-HOME RESPITE** B. Agency Provider Requirement 1. The agency is responsible to ensure that the direct support professionals (RN, LPN, and HHA) meet all applicable MFW, State and Federal requirements for PDN and HHA. 2. The agency will follow the MFW PDN and HHA Standards. 3. Respite services must be provided by qualified personnel as delineated in the agency's licensure requirements and follow the MFW Standards and the MFW Provider Agreement. 4. Advance notice to the CM is required. This includes a timeline from the person/person's representative. 5. A log of respite hours used must be established and maintained. 6. The CM must complete and approve required paperwork for the agency's respite services prior to implementation. 7. All services provided during respite must be documented following the documentation standards by the MFW, State, Federal and agency requirements. 8. The agency personnel must be culturally sensitive to the needs and preferences of person and members of their household. Arrangement of written or spoken communication in another language may need to be considered.			

TAG # MF23 Private Duty Nursing – Agency/Individual Requirements			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **PRIVATE DUTY NURSING** **II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS** **E. Requirements for the HH Agency Serving the Medically Fragile Waiver Population:** 1. A RN or LPN in the state of New Mexico must maintain current licensure as required by the state of New Mexico Board of Nursing. The HH Agency will maintain verification of current licensure. Nursing experience in the area of developmental disabilities and/or medically fragile conditions is preferred. 2. When the HH Agency deems the nursing applicant's experience does not meet MFW Standards, 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 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 Supervisors(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 participant, participant representative and households. Arrangement of written or spoken communication in another language must be considered.	Based on record review the Agency did not ensure documented monthly contact that reflects the discussion and review of services and ongoing coordination of care for 1 of 3 Individuals reviewed. **Review of Agency case files revealed no evidence of monthly contact between the case manager and direct service provider for the following:** • Individual #3 – None found for 6/2020.	**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?)*: → **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?)*: →	

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 person'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 must document in the participant's clinical file RN supervision to occur at least every sixty (60) days. Supervisory forms must be developed and implemented specifically for this task. 9. The HH Agency and CM must have documented monthly contact that reflects the discussion and review of services and ongoing coordination of care. 10. The HH Agency supervising RN, direct care RN, and LPN trains 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. 11. It is expected that the HH Agency will consult with the participant, IDT members, guardians, family, and DSP as needed.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Medicaid Billing/Reimbursement:			
TAG #MF 1A12 All Services Reimbursement (No Deficiencies)			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **VI. DOCUMENTATION** A. Provider agencies must maintain all records necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to individuals who are currently receiving services. The provider agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, level of services, and length of service billed. B. The documentation of the billable time spent with an individual are kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record must contain at least the following information: a. date and start and end time of each service encounter or other billable service interval; b. description of what occurred during the encounter or service interval; and c. signature and title of staff providing the service verifying that the service and time are correct. **<u>RESPITE STANDARDS</u>** **III. REIMBURSEMENT** Each provider agency of a service is responsible for developing clinical documentation that identifies the direct support	Based on record review, the Agency maintained all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving Respite Private Duty Nursing, for 3 of 3 Individuals served. *Progress notes and billing records supported billing activities for the month of September of 2020.*		

professionals' 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 person's clinical record supporting medical necessity for the care and for the approved Level of Care, that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant's representative, other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget. A. Payment for respite services through the MFW is considered payment in full. B. The respite services must abide by all Federal, State and Human Services Department (HSD) and DOH policies and procedures regarding billable and non-billable items. C. All billed services must not exceed the capped dollar amount for respite services. D. Reimbursement for respite services will be based on the current rate allowed for the services. E. The agency must follow all current billing requirements by the HSD and DOH for respite services. F. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC. G. Service providers have the responsibility to review and assure that the information on the MAD 046 form is current. If the provider identifies an error, he/she will contact the CM or a supervisor at the case management agency immediately to have the error corrected.			

H. The MFW Program does not consider the following to be respite service duties and will not authorize payment for: 1. Performing errands for the participant/participant's representative or family that is not program specific; 2. "Friendly visiting," meaning visiting with the person outside of respite 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 the medically fragile participant; 6. Pick up and/or delivery of commodities; and 7. Other non-Medicaid reimbursable activities. **NMAC 8.314.3.17 Reimbursement:** Waiver service providers must submit claims for reimbursement to MAD's fiscal contractor for processing. Claims must be filed per the billing instructions in the medicaid policy manual. Providers must follow all medicaid billing instructions. See Section 8.302.2 NMAC. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to providers of medicaid waiver services is made at a predetermined reimbursement rate. [8.314.3.17 NMAC - Rp, 8 .314.3.17 NMAC, 3/1/2018]			

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DR. TRACIE C. COLLINS, M.D.
Secretary-Designate

Date: February 5, 2021

To: Judy M. Sanchez, MBA, Administrator
Provider: Children's Home Healthcare, Inc. (DJK Home Healthcare, LLC)
Address: 4600 A. Montgomery Blvd. NE Ste. A-101
State/Zip: Albuquerque, New Mexico 87109

E-mail Address: judy@childrenshha.com

CC: Kara Gaut, RN, Board of Directors Chairperson
E-Mail Address kara@childrenshha.com

Region: Metro and Northeast
Survey Date: November 9 - 19, 2020
Program Surveyed: Medically Fragile Waiver (MFW)

Service Surveyed: Respite Private Duty Nursing (PDN)

Survey Type: Routine

Dear Ms. Sanchez:

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,

Monica Valdez, BS

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

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