NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DAVID R. SCRASE, M.D.
Acting Cabinet Secretary

Date:	August 10, 2022
To:	Ryan Sherman, Owner / Director
Provider: Address: State/Zip:	Ability First, LLC. 2610 San Mateo Blvd NE Albuquerque, New Mexico 87110
E-mail Address:	ryansherman@ability1st.com
CC: Email Address:	Brenda Resendiz, Programs Director bresendiz@ability1st.com
CC: Email Address:	Chelsey Hester, Operations Director chester@arizonaautism.com
CC: Email Address:	Lianne Lopez, RN / Director of Nursing llopez@ability1st.com
CC: Email Address:	Lynanne Gallegos, SL Director lgallegos@ability1st.com
Region: Survey Date:	Metro May 27 – June 13, 2022
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Supported Living, Family Living, Customized In-Home Supports; Customized Community Supports, and Community Integrated Employment Services
Survey Type:	Routine
Team Leader:	Heather Driscoll, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Alyssa Swisher, RN, Nurse Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Amanda Castaneda – Holguin, MPA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Beverly Estrada, ADN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Elizabeth Vigil, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jorge Sanchez – Enriquez, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Joshua Burghart, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Kayla Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Lei Lani Nava, MPH, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Sally Rel, MS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Verna Newman – Sikes, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Wolf Krusemark, BFA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Ryan Sherman;

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:

Non-Compliance: This determination is based on noncompliance with 17 or more total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level tag or any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags *(refer to Attachment D for details)*. The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- Tag # 1A22 Agency Personnel Competency
- Tag # 1A05 General Requirements / Agency Policy and Procedure Requirements
- Tag # 1A09 Medication Delivery Routine Medication Administration
- Tag # 1A09.1 Medication Delivery PRN Medication Administration
- Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File (Other Required Documents)
- Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components
- Tag # 1A08.1 Administrative and Residential Case File: Progress Notes
- Tag # 1A32 Administrative Case File: Individual Service Plan Implementation
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)
- Tag # IS04 Community Life Engagement
- Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)
- Tag # 1A43.1 General Events Reporting: Individual Reporting
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A09.1.0 Medication Delivery PRN Medication Administration
- Tag # 1A33.1 Board of Pharmacy – License
- Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)
- Tag # IS30 Customized Community Supports Reimbursement

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 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

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

Sincerely,

Heather Driscoll, AA

Heather Driscoll, AA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	May 27, 2022
Contact:	**Ability First, LLC.** Ryan Sherman, Owner / Director **DOH/DHI/QMB** Heather Driscoll, AA, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	*Entrance Conference Waived*
Exit Conference Date:	June 13, 2022
Present:	**Ability First, LLC.** Lynanne Gallegos, SL Director Chelsey Hester, Operations Director Lianne Lopez, RN / Director of Nursing Brenda Resendiz, Programs Director Ryan Sherman, Owner / Director **DOH/DHI/QMB** Heather Driscoll, AA, Team Lead/Healthcare Surveyor Joshua Burghart, BS, Healthcare Surveyor Amanda Castaneda – Holguin, MPA, Healthcare Surveyor Supervisor Beverly Estrada, ADN, Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Lei Lani Nava, MPH, Healthcare Surveyor Verna Newman – Sikes, AA, Healthcare Surveyor Sally Rel, MS, Healthcare Surveyor Jorge Sanchez – Enriquez, BS, Healthcare Surveyor Alyssa Swisher, RN, Nurse Healthcare Surveyor Valarie Valdez, MS, Bureau Chief Elizabeth Vigil, Healthcare Surveyor **DDSD - Metro Regional Office** Linda Clark, Assistant Regional Director Alicia Otolo, Social and Community Coordinator
Administrative Locations Visited:	1 (2610 San Mateo Blvd NE, Albuquerque NM 87110)
Total Sample Size:	24 0 - *Jackson* Class Members 24 - Non-*Jackson* Class Members 10 - Supported Living 10 - Family Living 2 - Customized In-Home Supports 12 - Customized Community Supports 5 - Community Integrated Employment
Total Homes Visited	14
❖ Supported Living Homes Visited	6 *Note: The following Individuals share a SL residence:* ➢ #3, 8, 20

	➢ #1, 18 ➢ #12, 14
❖ Family Living Homes Visited	8 *(Note: 1 FL home was not visited due to the individual being out of the country.)* *Note: The following Individuals share a FL residence:* ➢ #16, 21
Persons Served Records Reviewed	24
Persons Served Interviewed	17
Persons Served Observed	2 *(Note: Two Individuals chose not to participate in the interview process.)*
Persons Served Not Seen and/or Not Available	5
Direct Support Personnel Records Reviewed	164 *(Note: 1 DSP performs dual role as Service Coordinator)*
Direct Support Personnel Interviewed	28
Substitute Care/Respite Personnel Records Reviewed	4
Service Coordinator Records Reviewed	5 *(Note: 1 Service Coordinator performs dual role as DSP)*
Nurse Interview	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 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 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 <u>Living Care Arrangements and Community Inclusion</u> are as follows:

<u>Service Domain: Service Plan: ISP Implementation -</u> *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)

<u>Service Domain: Qualified Providers -</u> *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 Coordination - Nurse Availability / Knowledge
- **1A31 –** Client Rights/Human Rights
- **LS25.1 –** Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

Attachment C

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

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

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

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

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

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

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

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

Partial-Compliance with Standard Level Tags:

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

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.

2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

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

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

Non-Compliance:

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

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

2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

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

Agency: **Ability First, LLC. – Metro Region**
Program: Developmental Disabilities Waiver
Service: Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports, and Community Integrated Employment Services
Survey Type: Routine
Survey Date: **May 27 – June 13, 2022**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI, and Responsible Party	Completion Date
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency specified in the service plan.*			
Tag # 1A08 Administrative Case File (Other Required Documents)	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to 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,	Based on record review the Agency did not maintain a complete and confidential case file at the administrative office for 6 of 24 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **ISP budget forms: MAD 046 / Budget Worksheet:** • Not Found (#7) **Behavior Crisis Intervention Plan:** • Not Found (#22, 24) **Speech Therapy Plan (Therapy Intervention Plan TIP):** • Not Found (#13) **Physical Therapy Plan (Therapy Intervention Plan TIP)**: • Not Found (#6) **Documentation of Guardianship/Power of Attorney:** • Not Found (#19)	**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?)*: →	

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 DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. ***20.5.1 Individual Data Form (IDF):*** The Individual Data Form provides an overview of demographic information as well as other key personal, programmatic, insurance, and health related information. It lists medical information; assistive technology or adaptive equipment; diagnoses; allergies; information about whether a guardian or advance directives are in place; information about behavioral and health related needs; contacts of Provider Agencies and team members and other critical information. The IDF automatically loads information into other fields and forms and must be complete and kept current. This form is initiated by the CM. It must be opened and			

continuously updated by Living Supports, CCS- Group, ANS, CIHS and case management when applicable to the person in order for accurate data to auto populate other documents like the Health Passport and Physician Consultation Form. Although the Primary Provider Agency is ultimately responsible for keeping this form current, each provider collaborates and communicates critical information to update this form. **Chapter 3: Safeguards 3.1.2 *Team Justification Process***: DD Waiver participants may receive evaluations or reviews conducted by a variety of professionals or clinicians. These evaluations or reviews typically include recommendations or suggestions for the person/guardian or the team to consider. The team justification process includes: 1. Discussion and decisions about non-health related recommendations are documented on the Team Justification form. 2. The Team Justification form documents that the person/guardian or team has considered the recommendations and has decided: a. to implement the recommendation; b. to create an action plan and revise the ISP, if necessary; or c. not to implement the recommendation currently. 3. All DD Waiver Provider Agencies participate in information gathering, IDT meeting attendance, and accessing supplemental resources if needed and desired. 4. The CM ensures that the Team Justification Process is followed and complete.			

Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	Standard Level Deficiency		
NMAC 7.26.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY. **NMAC 7.26.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS.** **NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS.** Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 6 Individual Service Plan:** The CMS requires a person-centered service plan for every person receiving HCBS. The DD Waiver's person-centered service plan is the ISP. ***6.5.2 ISP Revisions:*** The ISP is a dynamic document that changes with the person's desires, circumstances, and need. IDT members must collaborate and request an IDT meeting from the CM when a need to modify the ISP arises. The CM convenes the IDT within ten days of receipt of any reasonable request to convene the team, either in person or through teleconference. **6.6 DDSD ISP Template:** The ISP must be written according to templates provided by the DDSD. Both children and adults have designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e., an acknowledgement of receipt of specific	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 2 of 24 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **ISP Teaching and Support Strategies:** **Individual #12:** *TSS not found for the following Live Outcome Statement / Action Steps:* • "…will research a recipe he would like to make." • "With staff help, …will make a dish." *TSS not found for the following Work / Learn Outcome Statement / Action Steps:* • "…will complete his job tasks professionally." **Individual #22:** *TSS not found for the following Work / Learn Outcome Statement / Action Steps:* • "…will insert Patch Codes."	**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?)*: →	

information) and other elements depending on the age of the individual. The ISP templates may be revised and reissued by DDSD to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDSD and be required for use in order to better demonstrate required elements of the PCP process and ISP development. The ISP is completed by the CM with the IDT input and must be completed according to the following requirements: 1. DD Waiver Provider Agencies should not recommend service type, frequency, and amount (except for required case management services) on an individual budget prior to the Vision Statement and Desired Outcomes being developed. 2. The person does not require IDT agreement/approval regarding his/her dreams, aspirations, and desired long-term outcomes. 3. When there is disagreement, the IDT is required to plan and resolve conflicts in a manner that promotes health, safety, and quality of life through consensus. Consensus means a state of general agreement that allows members to support the proposal, at least on a trial basis. 4. A signature page and/or documentation of participation by phone must be completed. 5. The CM must review a current Addendum A and DHI ANE letter with the person and Court appointed guardian or parents of a minor, if applicable. **6.6.3 Additional Requirements for Adults:** Because children have access to other funding sources, a larger array of services are available to adults than to children through the DD Waiver. (See Chapter 7: Available Services and Individual Budget Development). The ISP Template for adults is also more extensive, including Action Plans, Teaching			

and Support Strategies (TSS), Written Direct Support Instructions (WDSI), and Individual Specific Training (IST) requirements. **6.6.3.1. Action Plan:** Each Desired Outcome requires an Action Plan. The Action Plan addresses individual strengths and capabilities in reaching Desired Outcomes. Multiple service types may be included in the Action Plan under a single Desired Outcome. Multiple Provider Agencies can and should be contributing to Action Plans toward each Desired Outcome. 1. Action Plans include actions the person will take; not just actions the staff will take. 2. Action Plans delineate which activities will be completed within one year. 3. Action Plans are completed through IDT consensus during the ISP meeting. 4. Action Plans must indicate under "Responsible Party" which DSP or service provider (i.e., Family Living, CCS, etc.) are responsible for carrying out the Action Step. **6.6.3.2 Teaching and Supports Strategies (TSS) and Written Direct Support Instructions (WDSI):** After the ISP meeting, IDT members conduct a task analysis and assessments necessary to create effective TSS and WDSI to support those Action Plans that require this extra detail. All TSS and WDSI should support the person in achieving his/her Vision. **6.6.3.3 Individual Specific Training in the ISP:** The CM, with input from each DD Waiver Provider Agency at the annual ISP meeting, completes the IST requirements section of the ISP form listing all training needs specific to the individual. Provider Agencies bring their proposed IST to the annual meeting. The IDT must reach a consensus about who needs to be trained, at what level (awareness,			

knowledge, or skill), and within what timeframe. (See Chapter 17.10 Individual-Specific Training for more information about IST.) **6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.			

Tag # 1A08.1 Administrative and Residential Case File: Progress Notes	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to 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	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 11 of 24 Individuals. Review of the Agency individual case files revealed the following items were not found: **Administrative Case File:** **Supported Living Progress Notes/Daily Contact Logs:** **Agency progress notes reflected the start and end of the staff shifts with no clear indication of when the Individual transitioned to a different DDW service or return from that service. Per the DDSD Standards progress notes must contain the required start and end time of each service encounter. This occurred for the following:** • Individual #1 – 3/1 – 3, 23, 25 - 31, 4/1 – 29, 2022. • Individual #3 – 3/1 – 31, 4/1 – 30, 2022. • Individual #8 – 3/25, 27 – 31, 4/1 – 15, 17 – 30, 2022. • Individual #12 – 3/4 – 31, 4/1 – 15, 18 – 28, 2022. • Individual #14 – 4/15, 21, 22, 24, 2022. • Individual #18 – 3/1 – 15, 18 – 31, 4/1 – 30, 2022. • Individual #22 – 3/1 – 31, 4/1 – 30, 2022. • Individual #23 – 3/1 – 31, 4/1 – 30, 2022.	**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?)*: →	

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 DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.	**Family Living Progress Notes/Daily Contact Logs:** **Agency progress notes reflected minimal description of services provided, including minimal description of how the Individual participated in services, what assistance was needed and what occurred during services. This occurred for the following:** • Individual #4 – Notes contained minimal description for example, in March and April 2022, notes indicated the following; *Morning: "Woke up got ready." Afternoon: "Went to store, did chores." Evening: "Got home, dinner, went to sleep." Notes reflected the same pattern daily without a full description of what was provided.* • Individual #7 – Notes contained minimal description for example, in March and April 2022, notes indicated the following; *Morning: "We made breakfast." Afternoon: "We made popcorn." Evening: "We did Yoga." Notes reflected the same pattern daily without a full description of what was provided.* • Individual #19 – Notes contained minimal description for example, in March and April 2022, notes indicated the following; *Morning: "He brushes his teeth." Afternoon: "I help prepare dinner." Evening: "He watered the plants." Notes reflected the same pattern daily without a full description of what was provided.* **Customized Community Services Notes/Daily Contact Logs:**		

	• Individual #23 - None found for 3/1 – 3, 7 – 11, 15, 17 – 18, 21 - 25, 29 -31, 4/6 – 8, 19, 22, 26 – 28, 2022.		

Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests, and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and	Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 2 of 24 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #8 • None found regarding: Live Outcome/Action Step: "…will come up with things he would like to add to his daily routine and add it to his monthly calendar" for 3/2022. Action step is to be completed 1 time per month. • None found regarding: Live Outcome/Action Step: "…will complete his hygiene regimen of washing, shaving, and changing into clean clothes" for 3/2022. Action step is to be completed 3 times per week. • None found regarding: Health Outcome/Action Step: "…will be provided various ideas and choose how he wants to exercise, walking, gym, etc." for 3/2022. Action step is to be completed 1 time per week. • None found regarding: Health Outcome/Action Step: "…will exercise" for 3/2022. Action step is to be completed 2 times per week.	**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?)*: →	

purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 6: Individual Service Plan (ISP) 6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents	**Customized Community Supports Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #6 • No Outcomes or DDSD exemption/decision justification found for Customized Community Support Services (Individual). As indicated by NMAC 7.26.5.14 “Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.”		

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 DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.			

Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests, and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities.	Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 6 of 24 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #3 • According to the Live Outcome; Action Step for "…will spend 1 hour with a pet" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2022. • According to the Live Outcome; Action Step for "…will play gently with the pet" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2022. Individual #8 • According to the Health Outcome; Action Step for "…will exercise" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/2022. Individual #15	**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?)*: →	

The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 6: Individual Service Plan (ISP) 6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following:	• According to the Live Outcome; Action Step for "…will choose exercise for the month" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2022 – 3/2022. • According to the Live Outcome; Action Step for "…will participate in exercise" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2022 – 3/2022. • According to the Live Outcome; Action Step for "…will create and upload video / photos of her doing exercise into catalogue" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2022 – 3/2022. Individual #19 • According to the Live Outcome; Action Step for "Put dirty clothes in washer with correct amount of detergent" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/2022. Individual #23 • According to the Live Outcome; Action Step for "…will complete the task of laundry" is to be completed 1 time weekly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2022 – 4/2022 . **Family Living Data Collection / Data Tracking/Progress with regards to ISP Outcomes:** Individual #4		

8. 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. 9. 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. 10. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 11. 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. 12. 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. 13. 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. 14. 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.	• According to the Live Outcome; Action Step for "…will clean her room" is to be completed 4 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/2022. • According to the Live Outcome; Action Step for "…will participate in virtual fitness classes" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2022 - 4/2022. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #15 • According to the Fun Outcome; Action Step for "…will research activity with staff" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2022 – 4/2022. • According to the Fun Outcome; Action Step for "…will plan activity with staff" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2022 – 4/2022.		

Tag # IS04 Community Life Engagement	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 11: Community Inclusion** **11.1 General Scope and Intent of Services:** Community Inclusion (CI) is the umbrella term used to describe services in this chapter. In general, CI refers to opportunities for people with I/DD to access and participate in activities and functions of community life. The DD waiver program offers Customized Community Supports (CCS), which refers to non-work activities and Community Integrated Employment (CIE) which refers to paid work experiences or activities to obtain paid work. CCS and CIE services are mandated to be provided in the community to the fullest extent possible. **11.3 Implementation of a Meaningful Day:** The objective of implementing a Meaningful Day is to plan and provide supports to implement the person's definition of his/her own meaningful day, contained in the ISP. Implementation activities of the person's meaningful day are documented in daily schedules and progress notes. 1. Meaningful Day includes: a. purposeful and meaningful work; b. substantial and sustained opportunity for optimal health; c. self-empowerment; d. personalized relationships; e. skill development and/or maintenance; and f. social, educational, and community inclusion activities that are directly linked to the vision, Desired Outcomes and Action Plans stated in the person's ISP. 2. Community Life Engagement (CLE) is also	Based on record review, the Agency did not have evidence of their implementation of a meaningful day in daily schedules / individual calendar and progress notes for 1 of 12 Individuals. Review of the individual case files found there is no individualized schedule that can be modified easily based on the individual needs, preferences, and circumstances and that outline planned activities per day, week and month including date, time, location, and cost of the activity: **Calendar / Daily Calendar**: • Not found (#23)	**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?)*: →	

sometimes used to refer to “Meaningful Day” or “Adult Habilitation” activities. CLE refers to supporting people in their communities, in non-work activities. Examples of CLE activities may include participating in clubs, classes, or recreational activities in the community; learning new skills to become more independent; volunteering; or retirement activities. Meaningful Day activities should be developed with the four guideposts of CLE in mind[1]. The four guideposts of CLE are: a. individualized supports for each person; b. promotion of community membership and contribution; c. use of human and social capital to decrease dependence on paid supports; and d. provision of supports that are outcome-oriented and regularly monitored. 3. The term “day” does not mean activities between 9:00 a.m. to 5:00 p.m. on weekdays. 4. Community Inclusion is not limited to specific hours or days of the week. These services may not be used to supplant the responsibility of the Living Supports Provider Agency for a person who receives both services.			

Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to 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	After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 10 of 20 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **ISP Teaching and Support Strategies:** **Individual #15:** *TSS not found for the following Live Outcome Statement / Action Steps:* • "…will chose exercise for the month." • "…will participate in exercise." *TSS not found for the following Fun / Relationship Outcome Statement / Action Steps:* • "…will research activity with staff." • "…will plan activity with staff." • "…will attend activity." **Individual #21:** *TSS not found for the following Health Outcome Statement / Action Steps:* • "…with staff assistance she will complete all the exercises as outlined in her PT Program." **Healthcare Passport:**	**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?)*: →	

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 DDSD 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. Requirements for the *Health Passport* and *Physician Consultation* form are: 2. The Primary and Secondary Provider Agencies must ensure that a current copy of the *Health Passport* and *Physician Consultation* forms are printed and available at all service delivery sites. Both forms must be reprinted and placed at all service delivery sites each time the e-CHAT is updated for any reason and whenever there is a change to contact information contained	• Not Found (#2, 5, 7, 15, 16, 17, 21) • Not Current (#11) **Comprehensive Aspiration Risk Management Plan:** • Not Found (#22) **Health Care Plans:** • Medications (#3) • Oral Hygiene (#16) • Psychiatric Hospitalization (#3) • Skin Integrity (#3) **Medical Emergency Response Plans:** • Allergies (#15) • Body Mass Index (#3) • Medications (#3) • Number of Psychoactive Medications (#3) • Psychiatric Hospitalization (#3)		

in the IDF. **Chapter 13: Nursing Services: 13.2.9 Healthcare Plans (HCP)*:*** 1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans. 2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary **13.2.10 *Medical Emergency Response Plan (MERP):*** 1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP. 2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.			

Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to 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	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 1 of 20 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **Positive Behavioral Supports Plan:** • Not Found (#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?)*: →	

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 DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI, and Responsible Party	Completion Date
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 # 1A22 Agency Personnel Competency	**Condition of Participation Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 13: Nursing Services *13.2.11 Training and Implementation of Plans:*** 1. RNs and LPNs are required to provide Individual Specific Training (IST) regarding HCPs and MERPs. 2. The agency nurse is required to deliver and document training for DSP/DSS regarding the healthcare interventions/strategies and MERPs that the DSP are responsible to implement, clearly indicating level of competency achieved by each trainee as described in Chapter 17.10 Individual-Specific Training. **Chapter 17: Training Requirement** **17.10 Individual-Specific Training:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan	After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not ensure training competencies were met for 11 of 28 Direct Support Personnel. **When DSP were asked, if the Individual had a Positive Behavioral Supports Plan (PBSP), have you been trained on the PBSP and what does the plan cover, the following was reported:** • DSP #573 stated, "Yes. Oh shoot, I've read it, but I don't know what it says right now." According to the Individual Specific Training section of the ISP the Individual requires a Positive Behavioral Supports Plan. (Individual #15) **When DSP were asked, if they received training on the Individual's Behavioral Crisis Intervention Plan (BCIP) and if so, what the plan covered, the following was reported:** • DSP #573 stated, "Yes, she does, but like I said, I don't know what it says." According to the Individual Specific Training Section of the ISP the individual has Behavioral Crisis Intervention Plan. (Individual #15) **When DSP were asked, if the Individual had a Comprehensive Aspiration Risk Management Plan (CARMP) and a series of**	**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?)***:** →	

described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence. Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported. 1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends. 2. IST for therapy related WDSI, HCPs, MERPs, CARMPs, PBSA, PBSP, and BCIP, must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds incorrect implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher. 3. The competency level of the training is based on the IST section of the ISP. 4. The person should be present for and involved in IST whenever possible.	**questions of how it is implemented, the following was reported:** • When asked how the person is positioned after eating, DSP #551 stated, "No." Per the Comprehensive Aspiration Risk Management Plan (CARMP) the individual must remain upright for 30 minutes following meals. (Individual #15) • DSP #509 stated, "No." As indicated by the Individual Specific Training section of the ISP the Individual has a Comprehensive Aspiration Risk Management Plan (CARMP). (Individual #22) **When DSP were asked, if the Individual's had Health Care Plans, where could they be located and if they had been trained, the following was reported:** • DSP #595 stated, "I believe so, but I can't recall if he does or not." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Body Mass Index and Psychoactive PRN Medications. (Individual #3) • DSP #552 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Body Mass Index. (Individual #5) • DSP #551 stated, "I believe so yes. I remember being trained on them, I just don't honestly remember." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Aspiration, Falls, Risk of Injury / Falls. (Individual #15)		

5. Provider Agencies are responsible for tracking of IST requirements. 6. Provider Agencies must arrange and ensure that DSP's are trained on the contents of the plans in accordance with timelines indicated in the Individual-Specific Training Requirements: Support Plans section of the ISP and notify the plan authors when new DSP are hired to arrange for trainings. 7. If a therapist, BSC, nurse, or other author of a plan, healthcare or otherwise, chooses to designate a trainer, that person is still responsible for providing the curriculum to the designated trainer. The author of the plan is also responsible for ensuring the designated trainer is verifying competency in alignment with their curriculum, doing periodic quality assurance checks with their designated trainer, and re-certifying the designated trainer at least annually and/or when there is a change to a person's plan.	• DSP #514 stated, "There is a Health Care Plan for BMI and I've been trained." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual additionally requires Health Care Plans for Respiratory. (Individual #23) • DSP #519 stated, "I know she does. They are in the book. Just the CARMP." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual additionally requires Health Care Plans for Body Mass Index and Constipation. (Individual #22) **When DSP were asked, if the Individual's had Medical Emergency Response Plans and where could they be located, the following was reported:** • DSP #595 stated, "Same as the HCP." As indicated by the Individual Specific Training section of the ISP the Individual requires Medical Emergency Response Plans for: BMI, Number of Psychoactive Medications, Psychiatric Hospitalization, and Skin Integrity. (Individual #3) • DSP #551 stated, "Yes. I remember being trained on them but again I don't know. It's kind of hard because I get mixed up with their teams." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Aspiration, Risk of Injury / Falls, and Seizures. (Individual #15) • DSP #509 stated, "No, she doesn't." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plan for Aspiration (Individual #22)		

	• DSP #519 stated, "I don't think so." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plan for Aspiration. (Individual #22) • DSP #514 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plan for Respiratory. (Individual #23) **When DSP were asked, if the Individual had any food and / or medication allergies that could be potentially life threatening, the following was reported:** • DSP #584 stated, "No allergies at all." As indicated by the Health Passport the individual is allergic to Amoxicillin. (Individual #8) • DSP #504 stated, "The individual is allergic to tomato products, he does not take any meds." As indicated by Health Passport the individual is allergic to Ceclor and Septra. (Individual #11) • DSP #584 stated, "No, he doesn't." As indicated by the Health Passport the individual is allergic to Sulfa. (Individual #20) • DSP #509 stated, "No, he doesn't." As indicated by the Health Passport the individual is allergic to Aspirin, Cephalosporins, Penicillin, and Sulfa. (Individual #22) • DSP #519 stated, "No." As indicated by the Health Passport the individual is allergic to		

	Aspirin, Cephalosporine, Penicillin, and Sulfa. (Individual #22) **When DSP were asked, what are the steps you need to take before assisting an individual with PRN medication, the following was reported:** • DSP #573 stated, "I don't think she takes PRNs." Per DDSD standards 13.2.12 Medication Delivery DSP not related to the Individual must contact nurse prior to assisting with medication. (Individual #15) **When Direct Support Personnel were asked, what State Agency do you report suspected Abuse, Neglect or Exploitation, the following was reported:** • DSP #595 stated, "DOH. It is posted in the home; I don't have it on me." Staff was not able to identify the State Agency as Division of Health Improvement. • DSP #500 stated, "Unsure right now, I don't have that information in front of me. I don't know." Staff was not able to identify the State Agency as Division of Health Improvement. • DSP #638 stated, "NMDOH, (855) 600-3453." Staff did not identify the correct reporting number to the Division of Health Improvement Incident Management Bureau.		

Tag # 1A43.1 General Events Reporting: Individual Reporting	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 19: Provider Reporting Requirements: 19.2 General Events Reporting (GER):** The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Provider Agency use of GER in Therap is required as follows: 1. DD Waiver Provider Agencies approved to provide Customized In-Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use GER in the Therap system. 2. DD Waiver Provider Agencies referenced above are responsible for entering specified information into the GER section of the secure website operated under contract by Therap according to the GER Reporting Requirements in Appendix B GER Requirements. 3. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap. 4. GER does not replace a Provider Agency's obligations to report ANE or other	Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 9 of 24 individuals. **The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within the required timeframe:** **Individual #8** • General Events Report (GER) indicates on 3/25/2022 the Individual assaulted someone, and Law Enforcement was used. (Use of Law Enforcement). GER was approved 4/6/2022. • General Events Report (GER) indicates on 5/20/2022 the Individual injured himself while walking. (Injury). GER was approved 5/30/2022. **Individual #12** • General Events Report (GER) indicates on 6/3/2021 the Individual was cleaning the kitchen and fell. (Fall without Injury). GER was approved 6/10/2021. • General Events Report (GER) indicates on 7/7/2021 the Individual lost his balance and scraped his hand on the wall. (Injury). GER was approved 7/13/2021. • General Events Report (GER) indicates on 11/17/2021 the Individual received his COVID-19 vaccine. (COVID-19). GER was approved 2/1/2022.	**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?)*: →	

reportable incidents as described in Chapter 18: Incident Management System. 5. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities. **Appendix B GER Requirements:** DDSD is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting: 1. *Effective immediately*, DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to Division of Health Improvement-Incident Management Bureau. 2. No alternative methods for reporting are permitted. **<u>The following events need to be reported in the Therap GER:</u>** • Emergency Room/Urgent Care/Emergency Medical Services • Falls Without Injury • Injury (including Falls, Choking, Skin Breakdown and Infection) • Law Enforcement Use • Medication Errors • Medication Documentation Errors • Missing Person/Elopement • Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission • PRN Psychotropic Medication • Restraint Related to Behavior • Suicide Attempt or Threat **<u>Entry Guidance:</u>** Provider Agencies must complete the following sections of the GER with detailed information: profile information, event information, other event information,	• General Events Report (GER) indicates on 2/23/2022 the Individual had a COVID-19 test. (COVID-19). GER was approved 3/7/2022. • General Events Report (GER) indicates on 4/11/2022 the Individual had a COVID-19 test. (COVID-19). GER was approved 4/15/2022. **Individual #14** • General Events Report (GER) indicates on 11/16/2021 the Individual had a Covid-19 vaccine. (COVID-19). GER was approved 12/28/2021. • General Events Report (GER) indicates on 1/17/2022 the Individual was exposed to Covid-19. (COVID-19). GER was approved 1/24/2022. • General Events Report (GER) indicates on 2/23/2022 the Individual was exposed to Covid-19. (COVID-19). GER was approved 3/7/2022. • General Events Report (GER) indicates on 5/6/2022 the Individual was exposed to Covid-19. (COVID-19). GER was approved 5/13/2022. **Individual #15** • General Events Report (GER) indicates on 2/21/2022 the Individual was exposed to Covid-19. (COVID-19). GER was approved 3/7/2022. • General Events Report (GER) indicates on 2/25/2022 the Individual had rolled off her bed while sleeping. (Fall Without Injury). GER was approved 3/9/2022.		

general information, notification, actions taken or planned, and the review follow up comments section. Please attach any pertinent external documents such as discharge summary, medical consultation form, etc. Provider Agencies must enter and approve GERs within 2 business days with the exception of Medication Errors which must be entered into GER on at least a monthly basis.	• General Events Report (GER) indicates on 4/28/2022 the Individual fell while picking up something off the floor. (Fall Without Injury). GER was approved 5/5/2022. **Individual #16** • General Events Report (GER) indicates on 1/22/2022 the Individual fell going down the stairs. (Fall Without Injury). GER was approved 1/31/2022. **Individual #17** • General Events Report (GER) indicates on 10/22/2021 the Individual tested positive for COVID. (COVID–19). GER was approved 11/2/2021. **Individual #21** • General Events Report (GER) indicates on 6/14/2021 the Individual fell. (Fall without Injury). GER was approved 6/23/2021. • General Events Report (GER) indicates on 9/4/2021 the Individual fell. (Fall without Injury). GER was approved 9/15/2021. **Individual #23** • General Events Report (GER) indicates on 2/12/2021 the Individual had a COVID–19 vaccine. (COVID–19). GER was approved 2/24/2021. **The following events were not reported in the General Events Reporting System as required by policy:** **Individual #3** • Documentation reviewed indicates on 9/20/2021 the individual went to the ER. (Emergency Medicine). No GER was found.		

	• Documentation reviewed indicates on 11/19/2021 the individual was tested for COVID-19. (COVID-19). No GER was found. • Documentation reviewed indicates on 1/15/2022 the individual was tested for COVID-19. (COVID-19). No GER was found. • Documentation reviewed indicates on 1/26/2022 the individual was tested for COVID-19. (COVID-19). No GER was found. • Documentation reviewed indicates on 2/7/2022 the individual was given a PRN Psychotropic Medication. (PRN Psychotropic Medication). No GER was found. • Documentation reviewed indicates on 3/5/2022 the individual was given a PRN Psychotropic Medication. (PRN Psychotropic Medication). No GER was found. • Documentation reviewed indicates on 3/19/2022 the individual required the use of Police to be transported to the hospital. (Law Enforcement Involvement). No GER was found. • Documentation reviewed indicates on 3/22/2022 the individual was given a PRN Psychotropic Medication. (PRN Psychotropic Medication). No GER was found. • Documentation reviewed indicates on 3/24/2022 the individual was given a PRN Psychotropic Medication. (PRN		

	Psychotropic Medication). No GER was found. • Documentation reviewed indicates on 3/25/2022 the individual required the use of CIT and Police to be transported to the hospital. (Law Enforcement Involvement). No GER was found. • Documentation reviewed indicates on 3/28/2022 the individual was given a PRN Psychotropic Medication. (PRN Psychotropic Medication). No GER was found. • Documentation reviewed indicates on 4/6/2022 the individual was given a PRN Psychotropic Medication. (PRN Psychotropic Medication). No GER was found. • Documentation reviewed indicates on 4/9/2022 the individual was given a PRN Psychotropic Medication. (PRN Psychotropic Medication). No GER was found. • Documentation reviewed indicates on 4/15/2022 the individual was given a PRN Psychotropic Medication. (PRN Psychotropic Medication). No GER was found. • Documentation reviewed indicates on 4/27/2022 the individual was given a PRN Psychotropic Medication. (PRN Psychotropic Medication). No GER was found. • Documentation reviewed indicates on 4/28/2022 the individual was given a PRN Psychotropic Medication. (PRN		

	Psychotropic Medication). No GER was found. • Documentation reviewed indicates on 4/29/2022 the Individual cut his finger. (Injury). No GER was found. • Documentation reviewed indicates on 4/29/2022 the individual was given a PRN Psychotropic Medication. (PRN Psychotropic Medication). No GER was found.		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI, and Responsible Party	Completion Date
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	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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: 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: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such	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 3 of 24 individuals receiving Living Care Arrangements and Community Inclusion. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Living Care Arrangements / Community Inclusion (Individuals Receiving Multiple Services):*** **Annual Physical:** • Not Found (#7, 19) **Podiatry:** • Individual #14 - As indicated by collateral documentation reviewed, exam was completed on 9/15/2022. Exam was not linked / attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)*	**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?)*: →	

as the Individual Quality Review (IQR) or other DOH review or oversight activities; and d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 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: 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. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain			

individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to 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 DDSD 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.			

Tag # 1A05 General Requirements / Agency Policy and Procedure Requirements	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 16: Qualified Provider Agencies** Qualified DD Waiver Provider Agencies must deliver DD Waiver services. DD Waiver Provider Agencies must have a current Provider Agreement and continually meet required screening, licensure, accreditation, and training requirements as well as continually adhere to the DD Waiver Service Standards. All Provider Agencies must comply with contract management activities to include any type of quality assurance review and/or compliance review completed by DDSD, the Division of Health Improvement (DHI) or other state agencies. **NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION: Provider Application** • Emergency and on-call procedures; • On-call nursing services that specifically state the nurse must be available to DSP during periods when a nurse is not present. The on-call nurse must be available to make an on-site visit when information provided by the DSP over the phone indicate, in the nurse's professional judgment, a need for a face-to-face assessment to determine appropriate action; • Incident Management Procedures that comply with the current NM Department of Health Improvement Incident Management Guide • Medication Assessment and Delivery Policy and Procedure; • Policy and procedures regarding delegation	After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not develop, implement and / or comply with written policies and procedures to protect the physical/mental health of individuals that complies with all DDSD requirements. **When DSP were asked, how long does it take them to respond to you if you call, the following was reported:** • DSP #551 stated, "Majority of the time she won't really answer, sometimes she says she won't hear her phone, then I text/call/text and she won't respond right away, usually 30 or 40 minutes." (Individual #15)	**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?)*: →	

of specific nursing functions • Policies and procedures regarding the safe transportation of individuals in the community and how you will comply with the New Mexico regulations governing the operation of motor vehicles **STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 39. POLICIES AND REGULATIONS** Provider Agreements and amendments reference and incorporate laws, regulations, policies, procedures, directives, and contract provisions not only of DOH, but of HSD. Additionally, the PROVIDER agrees to abide by all the following, whenever relevant to the delivery of services specified under this Provider Agreement: a. DD Waiver Service Standards and MF Waiver Service Standards. b. DEPARTMENT/DDSD Accreditation Mandate Policies. c. Policies and Procedures for Centralized Admission and Discharge Process for New Mexicans with Disabilities. d. Policies for Behavior Support Service Provisions. e. Rights of Individuals with Developmental Disabilities living in the Community, 7.26.3 NMAC. f. Service Plans for Individuals with Developmental Disability Community Programs, 7.26.5 NMAC. g. Requirement for Developmental Disability Community Programs, 7.26.6 NMAC. h. DEPARTMENT Client Complaint Procedures, 7.26.4 NMAC. i. Individual Transition Planning Process, 7.26.7 NMAC. j. Dispute Resolution Process, 7.26.8 NMAC.			

k. DEPARTMENT/DDSD Training Policies and Procedures. l. Fair Labor Standards Act. m. New Mexico Nursing Practice Act and New Mexico Board of Nursing requirements governing certified medication aides and administration of medications, 16.12.5 NMAC. n. Incident Reporting and Investigation Requirements for Providers of Community Based Services, 7.14.3 NMAC, and DHI/DEPARTMENT Incident Management System Policies and Procedures. o. DHI/DEPARTMENT Statewide Mortality Review Policy and Procedures. p. Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. q. Quality Management System and Review Requirements for Providers of Community Based Services, 7.1.13 NMAC. r. All Medicaid Regulations of the Medical Assistance Division of the HS D. s. Health Insurance Portability and Accountability Act (HIPAA). t. DEPARTMENT Sanctions Policy. u. All other regulations, standards, policies and procedures, guidelines, and interpretive memoranda of the DDSD and the DHI of the DEPARTMENT. **Chapter 18 Incident Management: 18.1 Training on Abuse, Neglect, and Exploitation (ANE) Recognition and Reporting:** All employees, contractors, and volunteers shall be trained on the in-person ANE training curriculum approved by DOH. Employees or volunteers can work with a DD Waiver participant prior to receiving the training only if directly supervised, at all times, by a trained staff. Provider Agencies are responsible for ensuring the training requirements outlined below are met. 1. DDSD ANE On-line Refresher trainings shall be renewed annually,			

within one year of successful completion of the DDSD ANE classroom training. 2. Training shall be conducted in a language that is understood by the employee, subcontractor, or volunteer. 3. Training must be conducted by a DOH certified trainer and in accordance with the Train the Trainer curriculum provided by the DOH. 4. Documentation of an employee, subcontractor or volunteer's training must be maintained for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **B. Training curriculum:** Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic			

reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer. **D. Training documentation:** All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule. **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **F. Quality assurance/quality improvement program for community-based service providers:** The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based			

service provider shall provide the following internal monitoring and facilitating quality improvement program: **(1)** community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements; **(2)** community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and **(3)** community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.			

Tag # 1A09 Medication Delivery Routine Medication Administration	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR):** A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for: 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the	After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of May and June 2022. Based on record review, 3 of 12 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #14 May 2022 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • CBD 10mg Gummy (1 time daily) Individual #15 May 2022 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Cranberry Supplement 250mg (1 time daily) • Gentian Violet Topical Solution 1% (1 time daily) • Probiotic Drink 2.7 fl. oz (1 time daily) Individual #20 May 2022 Medication Administration Records contained missing entries. No	**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?)*: →	

counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments; d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and iii. documentation of the effectiveness of the PRN medication or treatment. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training;	documentation found indicating reason for missing entries: • Doxycycline Hyclate 100mg (2 times daily) – Blank 5/31 (8:00 AM)		

2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR). **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the			

administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24-hour period.			

Tag # 1A09.1 Medication Delivery PRN Medication Administration	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR):** A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for: 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the	After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of May 2022 and June 2022. Based on record review, 4 of 12 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #1 May 2022 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 200mg – PRN – 5/30 (given 1 time) • Lactase Enzyme Supplement – PRN – 5/31/2022 (given 1 time) Individual #3 May 2022 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Ibuprofen 200mg – PRN – 5/26 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Chlorpromazine 100mg – PRN – 5/25 (given 3 times), 5/31 (given 1 time) • Ibuprofen 200mg – PRN – 5/9 & 25 (given 1 time), 5/26 (given 2 times)	**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?)*: →	

counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments; d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and iii. documentation of the effectiveness of the PRN medication or treatment. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training;	As indicated by the Medication Administration Records the individual is to take Acetaminophen 500mg, 2 tablets every 6 hours (PRN). According to the Physician's Orders, the individual is to take Acetaminophen 500mg, 1 tablet every 4 hours (PRN). Medication Administration Record and Physician's Orders do not match. As indicated by the Medication Administration Records the individual is to take Ibuprofen 200mg, 2 tablets every 6 hours (PRN). According to the Physician's Orders, the individual is to take Ibuprofen 200mg, 1 – 2 tablet every 4 hours (PRN). Medication Administration Record and Physician's Orders do not match. As indicated by the Medication Administration Records the individual is to take Milk of magnesia Suspension 400mg / 5ml, 30ml by mouth at bedtime, no more than 2 doses in 24 hours (PRN). According to the Physician's Orders, the individual is to take Milk of magnesia Suspension 400mg / 5ml, 30ml by mouth followed by 8oz of water / juice. Give 1 dose per day, no more than 2 consecutive days (PRN). Medication Administration Record and Physician's Orders do not match. As indicated by the Medication Administration Records the individual is to take Tussin DM Cough Syrup 10 – 100mg / 5ml, 10ml by mouth every 4 hours, no more than 6 doses in 24 hours (PRN). According to the Physician's Orders, the individual is to take Tussin DM Cough Syrup 10 – 100mg / 5ml, 10ml by mouth every 6 hours, not to exceed 40ml in a 24-hours (PRN).		

2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).	Medication Administration Record and Physician's Orders do not match. Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Chlorpromazine 100mg (PRN) Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Benadryl 25mg (PRN) • Maalox / Mylanta 10ml (PRN) • MiraLAX 17gm (PRN) • Sudafed PE 10mg Individual #12 May 2022 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Guaifenesin 600mg (PRN) Individual #14 May 2022 No evidence of documented Signs/Symptoms were found for the following PRN • MiraLAX – PRN – 5/6, 16, 20 & 31 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • MiraLAX – PRN – 5/6, 16, 20 & 31 (given 1 time)		

Tag # 1A09.1.0 Medication Delivery PRN Medication Administration	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR):** A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for: 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the	Medication Administration Records (MAR) were reviewed for the months of May and June 2022. Based on record review, 1 of 12 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #20 May 2022 Medication Administration Records did not contain the exact amount to be used in a 24-hour period: • Ibuprofen 600mg (PRN)	**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?)*: →	

counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments; d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and iii. documentation of the effectiveness of the PRN medication or treatment. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training;			

2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).			

Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 13 Nursing Services: *13.2.12 Medication Delivery:*** Nurses are required to: 1. Be aware of the New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations. 2. Communicate with the Primary Care Practitioner and relevant specialists regarding medications and any concerns with medications or side effects. 3. Educate the person, guardian, family, and IDT regarding the use and implications of medications as needed. 4. Administer medications when required, such as intravenous medications; other specific injections; via NG tube; non-premixed nebulizer treatments or new prescriptions that have an ordered assessment. 5. Monitor the MAR or treatment records at least monthly for accuracy, PRN use and errors. 6. Respond to calls requesting delivery of PRNs from AWMD trained DSP and non-related (surrogate or host) Family Living Provider Agencies. 7. Assure that orders for PRN medications or treatments have: a. clear instructions for use; b. observable signs/symptoms or circumstances in which the medication is to be used or withheld; and c. documentation of the response to and effectiveness of the PRN medication administered. 8. Monitor the person's response to the use of routine or PRN pain medication and contact the prescriber as needed regarding its effectiveness. 9. Assure clear documentation when PRN	After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain documentation of PRN authorization as required by standard for 1 of 12 Individuals. Individual #3 May 2022 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Chlorpromazine 100mg – PRN – 5/2 (given 1 time) • Ibuprofen 200mg – PRN – 5/9 (given 1 time)	**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?)*: →	

medications are used, to include: a. DSP contact with nurse prior to assisting with medication. i. The only exception to prior consultation with the agency nurse is to administer selected emergency medications as listed on the Publications section of the DOH-DDSD -Clinical Services Website https://nmhealth.org/about/ddsd/pgsv/clinical/. b. Nursing instructions for use of the medication. c. Nursing follow-up on the results of the PRN use. d. When the nurse administers the PRN medication, the reasons why the medications were given and the person's response to the medication.			

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to 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	After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 10 of 24 individual Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Healthcare Passport:** ➢ Did not contain Name of Physician (#22) ➢ Did not contain Emergency Contact Information (#7, 8, 19, 21) *(Note: #7, 19 & 21 updated during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ➢ Did not contain Medical Diagnosis (#19) *(Note: #19 updated during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ➢ Did not contain Guardian / Healthcare Decision Maker (#1, 7, 8, 12, 19, 20, 21, 22) *(Note: #1, 7, 8, 19, 20 & 21 updated during the on-site survey. Provider please complete POC for ongoing QA/QI.)* **Health Care Plans:** ***Gastroesophageal Reflux Disorder:*** • Individual #16 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.	**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?)*: →	

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 DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **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: 2. 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: 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;	***Medication:*** • Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.		

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; c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 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: 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.			

Chapter 13 Nursing Services: ***13.2.5 Electronic Nursing Assessment and Planning Process:*** The nursing assessment process includes several DDSD mandated tools: the electronic Comprehensive Nursing Assessment Tool (e-CHAT), the Aspiration Risk Screening Tool (ARST) and the Medication Administration Assessment Tool (MAAT) . This process includes developing and training Health Care Plans and Medical Emergency Response Plans. The following hierarchy is based on budgeted services and is used to identify which Provider Agency nurse has primary responsibility for completion of the nursing assessment process and related subsequent planning and training. Additional communication and collaboration for planning specific to CCS or CIE services may be needed. The hierarchy for Nursing Assessment and Planning responsibilities is: 1. Living Supports: Supported Living, IMLS or Family Living via ANS; 2. Customized Community Supports- Group; and 3. Adult Nursing Services (ANS): a. for persons in Community Inclusion with health-related needs; or b. if no residential services are budgeted but assessment is desired and health needs may exist. ***13.2.6 The Electronic Comprehensive Health Assessment Tool (e-CHAT)*** 1. The e-CHAT is a nursing assessment. It may not be delegated by a licensed nurse to a non-licensed person. 2. The nurse must see the person face-to-face to complete the nursing assessment. Additional information may be gathered from members of the IDT and other sources. 3. An e-CHAT is required for persons in FL,			

SL, IMLS, or CCS-Group. All other DD Waiver recipients may obtain an e-CHAT if needed or desired by adding ANS hours for assessment and consultation to their budget. 4. When completing the e-CHAT, the nurse is required to review and update the electronic record and consider the diagnoses, medications, treatments, and overall status of the person. Discussion with others may be needed to obtain critical information. 5. The nurse is required to complete all the e-CHAT assessment questions and add additional pertinent information in all comment sections. ***13.2.7 Aspiration Risk Management Screening Tool (ARST)*** ***13.2.8 Medication Administration Assessment Tool (MAAT):*** 1. A licensed nurse completes the DDSD Medication Administration Assessment Tool (MAAT) at least two weeks before the annual ISP meeting. 2. After completion of the MAAT, the nurse will present recommendations regarding the level of assistance with medication delivery (AWMD) to the IDT. A copy of the MAAT will be sent to all the team members two weeks before the annual ISP meeting and the original MAAT will be retained in the Provider Agency records. 3. Decisions about medication delivery are made by the IDT to promote a person's maximum independence and community integration. The IDT will reach consensus regarding which criteria the person meets, as indicated by the results of the MAAT and the nursing recommendations, and the decision is documented this in the ISP. **13.2.9 Healthcare Plans (HCP)*:***			

1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans. 2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary report which is indicated by "R" in the HCP column. At the nurse's sole discretion, based on prudent nursing practice, HCPs may be combined where clinically appropriate. The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by "C" on the e-CHAT summary report. The nurse may also create other HCPs plans that the nurse determines are warranted. ***13.2.10 Medical Emergency Response Plan (MERP):*** 1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP. 2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.			

Chapter 20: Provider Documentation and Client Records: 20.5.3 Health Passport and Physician Consultation Form: All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form.			

Tag # 1A33.1 Board of Pharmacy - License	Standard Level Deficiency		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **Display of License and Inspection Reports** The following are required to be publicly displayed: • Current Custodial Drug Permit from the NM Board of Pharmacy • Current registration from the consultant pharmacist • Current NM Board of Pharmacy Inspection Report	Based on observation, the Agency did not provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 1 of 14 residences: **Individual Residence:** • Current Custodial Drug Permit from the NM Board of Pharmacy with the current address of the residence (#15)	**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?)*: →	

Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 10: Living Care Arrangements (LCA) 10.3.6 Requirements for Each Residence:** Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence: 1. has basic utilities, i.e., gas, power, water, and telephone; 2. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher; 3. has a general-purpose first aid kit; 4. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift; 5. has water temperature that does not exceed a safe temperature (110^0 F); 6. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP; 7. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy; 8. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; 9. supports environmental modifications and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised	Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 7 of 14 Living Care Arrangement residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Supported Living Requirements:** • Water temperature in home does not exceed safe temperature (110^0 F) ➢ Water temperature in home measured 126^0 F (#22) • Emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#15) • Emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy (#7, 15, 22) **Family Living Requirements:** • Poison Control Phone Number (#16, 19, 21) • Water temperature in home does not exceed safe temperature (110^0 F) ➢ Water temperature in home measured 128^0 F (#2) • Emergency placement plan for relocation of people in the event of an emergency	**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?)*: →	

toilets, etc.) based on the unique needs of the individual in consultation with the IDT; 10. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed; 11. has the phone number for poison control within line of site of the telephone; 12. has general household appliances, and kitchen and dining utensils; 13. has proper food storage and cleaning supplies; 14. has adequate food for three meals a day and individual preferences; and 15. has at least two bathrooms for residences with more than two residents.	evacuation that makes the residence unsuitable for occupancy (#16, 19, 21) *Note: The following Individuals share a residence:* ➢ #16, 21		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI, and Responsible Party	Completion Date
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 # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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: 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: 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. 4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 6 of 12 individuals. Individual #1 March 2022 • The Agency billed 13 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/1/2022. Documentation did not contain the required elements on 3/1/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 16 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/2/2022. Documentation did not contain the required elements on 3/2/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/3/2022. Documentation did not contain the required elements on 3/3/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service	**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?)*: →	

of the following for a period of at least six years from the payment date: a. treatment or care of any eligible recipient; b. services or goods provided to any eligible recipient; c. amounts paid by MAD on behalf of any eligible recipient; and d. any records required by MAD for the administration of Medicaid. **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. **21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following: 1. A day is considered 24 hours from midnight to midnight. 2. 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. 3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months. 4. 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: a. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%). b. The receiving Provider Agency bills the remaining days up to 340 for the ISP	• The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/25/2022. Documentation did not contain the required elements on 3/25/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 19 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/28/2022. Documentation did not contain the required elements on 3/28/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/29/2022. Documentation did not contain the required elements on 3/29/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 10 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/30/2022. Documentation did not contain the required elements on 3/30/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service		

year. **21.9.2 Requirements for Monthly Units:** For services billed in monthly units, a Provider Agency must adhere to the following: 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. **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: 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.	• The Agency billed 24 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/31/2022. Documentation did not contain the required elements on 3/31/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service April 2022 • The Agency billed 1 unit of Customized Community Supports (Individual) (H2021 HB-U1) on 4/1/2022. Documentation did not contain the required elements on 4/1/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 15 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/4/2022. Documentation did not contain the required elements on 4/4/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/8/2022. Documentation did not contain the required elements on 4/8/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service		

	• The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/9/2022. Documentation did not contain the required elements on 4/9/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 15 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/11/2022. Documentation did not contain the required elements on 4/11/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 15 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/12/2022. Documentation did not contain the required elements on 4/12/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 15 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/13/2022. Documentation did not contain the required elements on 4/13/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 14 units of Customized Community Supports (Individual) (H2021		

	HB-U1) on 4/14/2022. Documentation did not contain the required elements on 4/14/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 16 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/18/2022. Documentation did not contain the required elements on 4/18/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 17 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/22/2022. Documentation did not contain the required elements on 4/22/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 16 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/25/2022. Documentation did not contain the required elements on 4/25/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 23 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/26/2022. Documentation did not contain the required elements on		

	4/26/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service Individual #3 March 2022 • The Agency billed 19 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/1/2022. Documentation did not contain the required elements on 3/1/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 21 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/2/2022. Documentation did not contain the required elements on 3/2/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 19 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/3/2022. Documentation did not contain the required elements on 3/3/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/7/2022. Documentation did not contain the required elements on		

	3/7/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/8/2022. Documentation did not contain the required elements on 3/8/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/9/2022. Documentation did not contain the required elements on 3/9/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 21 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/10/2022. Documentation did not contain the required elements on 3/10/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 21 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/11/2022. Documentation did not contain the required elements on 3/11/2022. Documentation received		

	accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/14/2022. Documentation did not contain the required elements on 3/14/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 19 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/15/2022. Documentation did not contain the required elements on 3/15/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/16/2022. Documentation did not contain the required elements on 3/16/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 21 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/17/2022. Documentation did not contain the required elements on 3/17/2022. Documentation received accounted for 0 units. The required elements was not met:		

	➢ Services were provided concurrently with another service • The Agency billed 19 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/18/2022. Documentation did not contain the required elements on 3/18/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/21/2022. Documentation did not contain the required elements on 3/21/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 19 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/22/2022. Documentation did not contain the required elements on 3/22/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 13 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/23/2022. Documentation did not contain the required elements on 3/23/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service		

	• The Agency billed 19 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/24/2022. Documentation did not contain the required elements on 3/24/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/25/2022. Documentation did not contain the required elements on 3/25/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 19 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/28/2022. Documentation did not contain the required elements on 3/28/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 19 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/29/2022. Documentation did not contain the required elements on 3/29/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service		

	• The Agency billed 19 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/30/2022. Documentation did not contain the required elements on 3/30/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 19 units of Customized Community Supports (Individual) (H2021 HB-U1) from on 3/31/2022. Documentation did not contain the required elements on 3/31/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service April 2022 • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/1/2022. Documentation did not contain the required elements on 4/1/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/4/2022. Documentation did not contain the required elements on 4/4/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service		

	• The Agency billed 17 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/5/2022. Documentation did not contain the required elements on 4/5/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/6/2022. Documentation did not contain the required elements on 4/6/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/7/2022. Documentation did not contain the required elements on 4/7/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/8/2022. Documentation did not contain the required elements on 4/8/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021		

	HB-U1) on 4/11/2022. Documentation did not contain the required elements on 4/11/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 16 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/12/2022. Documentation did not contain the required elements on 4/12/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/13/2022. Documentation did not contain the required elements on 4/13/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/14/2022. Documentation did not contain the required elements on 4/14/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/15/2022. Documentation did not contain the required elements on		

	4/15/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/19/2022. Documentation did not contain the required elements on 4/19/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/20/2022. Documentation did not contain the required elements on 4/20/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/21/2022. Documentation did not contain the required elements on 4/21/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 19 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/25/2022. Documentation did not contain the required elements on 4/25/2022. Documentation received		

	accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/29/2022. Documentation did not contain the required elements on 4/29/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service Individual #5 March 2022 • The Agency billed 12 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/3/2022. Documentation did not contain the required elements on 3/3/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 24 units of Customized Community Supports (Group) (T2021 HB-U7) on 3/3/2022. Documentation did not contain the required elements on 3/3/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 11 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/17/2022. Documentation did not contain the required elements on 3/17/2022. Documentation received		

	accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 22 units of Customized Community Supports (Group) (T2021 HB-U7) on 3/17/2022. Documentation did not contain the required elements on 3/17/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 14 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/24/2022. Documentation did not contain the required elements on 3/24/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 24 units of Customized Community Supports (Group) (T2021 HB-U7) on 3/31/2022. Documentation did not contain the required elements on 3/31/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 12 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/31/2022. Documentation did not contain the required elements on 3/31/2022. Documentation received accounted for 0 units. The required elements was not met:		

	➢ Services were provided concurrently with another service April 2022 • The Agency billed 23 units of Customized Community Supports (Group) (T2021 HB-U7) on 4/7/2022. Documentation did not contain the required elements on 4/7/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 25 units of Customized Community Supports (Group) (T2021 HB-U7) on 4/14/2022. Documentation did not contain the required elements on 4/14/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 12 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/21/2022. Documentation did not contain the required elements on 4/21/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 1 units of Customized Community Supports (Group) (T2021 HB-U7) on 4/21/2022. Documentation did not contain the required elements on 4/21/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service		

	• The Agency billed 22 units of Customized Community Supports (Group) (T2021 HB-U7) on 4/28/2022. Documentation did not contain the required elements on 4/28/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service Individual #15 March 2022 • The Agency billed 26 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/1/2022. Documentation did not contain the required elements on 3/1/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 23 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/8/2022. Documentation did not contain the required elements on 3/8/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 62 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/15/2022. Documentation did not contain the required elements on 3/15/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service		

	• The Agency billed 27 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/17/2022. Documentation did not contain the required elements on 3/17/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 25 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/22/2022. Documentation did not contain the required elements on 3/22/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/24/2022. Documentation did not contain the required elements on 3/24/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/29/2022. Documentation did not contain the required elements on 3/29/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service		

	• The Agency billed 26 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/31/2022. Documentation did not contain the required elements on 3/31/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service April 2022 • The Agency billed 25 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/5/2022. Documentation did not contain the required elements on 4/5/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 32 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/7/2022. Documentation did not contain the required elements on 4/7/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 29 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/26/2022. Documentation did not contain the required elements on 4/26/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service		

	• The Agency billed 30 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/28/2022. Documentation did not contain the required elements on 4/28/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service Individual #22 March 2022 • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/2/2022. Documentation did not contain the required elements on 3/2/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 32 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/4/2022. Documentation did not contain the required elements on 3/4/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 21 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/7/2022. Documentation did not contain the required elements on 3/7/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service		

	• The Agency billed 24 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/11/2022. Documentation did not contain the required elements on 3/11/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 16 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/14/2022. Documentation did not contain the required elements on 3/14/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 23 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/16/2022. Documentation did not contain the required elements on 3/16/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 21 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/18/2022. Documentation did not contain the required elements on 3/18/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 15 units of Customized Community Supports (Individual) (H2021		

	HB-U1) on 3/21/2022. Documentation did not contain the required elements on 3/21/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 21 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/23/2022. Documentation did not contain the required elements on 3/23/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB-U1) on 3/25/2022. Documentation did not contain the required elements on 3/25/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service April 2022 • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/11/2022. Documentation did not contain the required elements on 4/11/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/12/2022. Documentation did		

	not contain the required elements on 4/12/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 29 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/13/2022. Documentation did not contain the required elements on 4/13/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 29 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/14/2022. Documentation did not contain the required elements on 4/14/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 27 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/15/2022. Documentation did not contain the required elements on 4/15/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/18/2022. Documentation did not contain the required elements on 4/18/2022. Documentation received		

	accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 29 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/19/2022. Documentation did not contain the required elements on 4/19/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 29 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/20/2022. Documentation did not contain the required elements on 4/20/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 29 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/21/2022. Documentation did not contain the required elements on 4/21/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 27 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/22/2022. Documentation did not contain the required elements on 4/22/2022. Documentation received accounted for 0 units. The required elements was not met:		

	➢ Services were provided concurrently with another service • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/25/2022. Documentation did not contain the required elements on 4/25/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 29 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/26/2022. Documentation did not contain the required elements on 4/26/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 30 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/27/2022. Documentation did not contain the required elements on 4/27/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/29/2022. Documentation did not contain the required elements on 4/29/2022. Documentation received accounted for 0 units. The required elements was not met: ➢ Services were provided concurrently with another service		

	Individual #23 March 2022 • The Agency billed 51 units of Customized Community Supports (Individual) (H2021 HB – U1) on 3/1/2022. No documentation was found 3/1/2022 to justify the 51 units billed. • The Agency billed 16 units of Customized Community Supports (Individual) (H2021 HB – U1) on 3/2/2022. No documentation was found 3/2/2022 to justify the 16 units billed. • The Agency billed 16 units of Customized Community Supports (Individual) (H2021 HB – U1) on 3/3/2022. No documentation was found 3/3/2022 to justify the 16 units billed. • The Agency billed 30 units of Customized Community Supports (Individual) (H2021 HB – U1) on 3/7/2022. No documentation was found 3/7/2022 to justify the 30 units billed. • The Agency billed 45 units of Customized Community Supports (Individual) (H2021 HB – U1) on 3/8/2022. No documentation was found 3/8/2022 to justify the 45 units billed. • The Agency billed 18 units of Customized Community Supports (Individual) (H2021 HB – U1) on 3/9/2022. No documentation was found 3/9/2022 to justify the 18 units billed. • The Agency billed 14 units of Customized Community Supports (Individual) (H2021 HB – U1) on 3/10/2022. No		

	documentation was found 3/10/2022 to justify the 14 units billed. • The Agency billed 1 units of Customized Community Supports (Individual) (H2021 HB – U1) on 3/11/2022. No documentation was found 3/11/2022 to justify the 1 units billed. • The Agency billed 24 units of Customized Community Supports (Group) (T2021 HB – U7) on 3/15/2022. No documentation was found 3/15/2022 to justify the 24 units billed. • The Agency billed 23 units of Customized Community Supports (Group) (T2021 HB – U7) on 3/17/2022. No documentation was found 3/17/2022 to justify the 23 units billed. • The Agency billed 31 units of Customized Community Supports (Individual) (H2021 HB – U1) on 3/18/2022. No documentation was found 3/18/2022 to justify the 31 units billed. • The Agency billed 25 units of Customized Community Supports (Individual) (H2021 HB – U1) on 3/21/2022. No documentation was found 3/21/2022 to justify the 25 units billed. • The Agency billed 16 units of Customized Community Supports (Group) (T2021 HB – U7) on 3/22/2022. No documentation was found 3/22/2022 to justify the 16 units billed. • The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB – U1) on 3/23/2022. No		

	documentation was found 3/23/2022 to justify the 23 units billed. • The Agency billed 23 units of Customized Community Supports (Group) (T2021 HB – U7) on 3/24/2022. No documentation was found 3/24/2022 to justify the 23 units billed. • The Agency billed 26 units of Customized Community Supports (Individual) (H2021 HB – U1) on 3/25/2022. No documentation was found 3/25/2022 to justify the 26 units billed. • The Agency billed 16 units of Customized Community Supports (Group) (T2021 HB – U7) on 3/29/2022. No documentation was found 3/29/2022 to justify the 16 units billed. • The Agency billed 32 units of Customized Community Supports (Individual) (H2021 HB – U1) on 3/30/2022. No documentation was found 3/30/2022 to justify the 32 units billed. • The Agency billed 23 units of Customized Community Supports (Group) (T2021 HB – U7) on 3/31/2022. No documentation was found 3/31/2022 to justify the 23 units billed. April 2022 • The Agency billed 26 units of Customized Community Supports (Individual) (H2021 HB – U1) on 4/6/2022. No documentation was found 4/6/2022 to justify the 26 units billed.		

	• The Agency billed 22 units of Customized Community Supports (Group) (T2021 HB – U7) on 4/7/2022. No documentation was found 4/7/2022 to justify the 22 units billed.
	
	• The Agency billed 30 units of Customized Community Supports (Individual) (H2021 HB – U1) on 4/8/2022. No documentation was found 4/8/2022 to justify the 30 units billed.
	
	• The Agency billed 24 units of Customized Community Supports (Individual) (H2021 HB-U1) on 4/11/2022. Documentation did not contain the required elements on 4/11/2022. Documentation received accounted for 0 units. The required elements was not met:
	  • Services were provided concurrently with another service
	
	• The Agency billed 1 units of Customized Community Supports (Group) (T2021 HB – U7) on 4/19/2022. No documentation was found 4/19/2022 to justify the 1 unit billed.
	
	• The Agency billed 30 units of Customized Community Supports (Individual) (H2021 HB – U1) on 4/22/2022. No documentation was found 4/22/2022 to justify the 30 units billed.
	
	• The Agency billed 30 units of Customized Community Supports (Individual) (H2021 HB-U1) from on 4/25/2022. Documentation did not contain the required elements on 4/25/2022. Documentation received accounted for 0 units. The required elements was not met:
	  • Services were provided concurrently with another service		

	• The Agency billed 16 units of Customized Community Supports (Group) (T2021 HB – U7) on 4/26/2022. No documentation was found 4/26/2022 to justify the 16 units billed. • The Agency billed 31 units of Customized Community Supports (Individual) (H2021 HB – U1) on 4/27/2022. No documentation was found 4/27/2022 to justify the 31 units billed. • The Agency billed 24 units of Customized Community Supports (Group) (T2021 HB – U7) on 4/28/2022. No documentation was found 4/28/2022 to justify the 24 units billed		

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DAVID R. SCRASE, M.D.
Acting Cabinet Secretary

Date:	July 14, 2022
To:	Amy Corbin, Executive Director
Provider:	Clovis Homecare, Inc. dba Community Homecare
Address:	1944 West 21st Street
State/Zip:	Clovis, New Mexico 88101
E-mail Address:	corbina@chomcare.biz
CC:	Carol Garrett
E-Mail Address:	cgarrett52@yahoo.com
Region:	Southeast
Survey Dates:	June 13 – 24, 2022
Program Surveyed:	Medically Fragile Waiver (MFW)
Service(s) Surveyed:	***Administrative Review Only.*** At the time of the survey the Agency was not serving any Medically Fragile Waiver Individuals in Home Health Aide (HHA), Private Duty Nursing (PDN), Respite PDN, or Respite
Survey Type:	Routine
Team Leader:	Jamie Pond, BS, QMB Staff Manager, Division of Health Improvement/Quality Management Bureau
Team Members:	Alyssa Swisher, RN, BSN, Nurse Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Corbin:

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 # MF 1A22 – Agency Personnel Competency
- Tag # MF 1A28.1 – Incident Management System – Agency Personnel Training
- Tag # MF 103 – Continuous Quality Improvement System
- Tag # MF 04 – General Provider Requirements
- Tag # MF 1A28 – Incident Management System

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

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.

If you have questions about the Report of Findings or Plan of Correction, please call the Plan of Correction Coordinator, Monica Valdez at (505) 273-1930. Thank you for your cooperation and for the work you perform.

Sincerely,

Jamie Pond, BS

Jamie Pond, BS
QMB Staff Manager / Team Lead
Division of Health Improvement / Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	**June 13, 2022**
Contact:	**Clovis Homecare, Inc. dba Community Homecare** Alexandrea Martinez, Assistant Director **DOH/DHI/QMB** Jamie Pond, BS, QMB Staff Manager / Team Lead
Entrance Date:	Agency waived entrance meeting
Exit Date:	June 24, 2022
Present:	**Clovis Homecare, Inc. dba Community Homecare** Alexandrea Martinez, Assistant Director / Human Resources Manager Amanda Stacy, RN, Director of Nursing **DOH/DHI/QMB** Jamie Pond, BS, QMB Staff Manager / Team Lead Alyssa Swisher, RN, BSN, Nurse Surveyor **DDSD – Clinical Services Bureau** Iris Clevenger, RN, MFW Program Manager
Administrative Locations Visited:	0 *(Note: No administrative locations visited due to COVID-19 Pandemic Public Health Emergency.)*
Total Sample Size:	0 (Admin survey only; no individuals served)
Home Health Aide Records Reviewed:	2
Home Health Aide Interviewed:	0 *(Note: Currently not providing services, as there are no individual receiving Medically Fragile Waiver services at the time of the survey)*
Private Duty Nursing Records Reviewed:	0 *(Note: Currently not providing services, as there are no individual receiving Medically Fragile Waiver services at the time of the survey)*
RN Supervisor Record(s) Reviewed:	1
RN Supervisor(s) Interviewed:	1 *(Note: Interviews conducted via video / phone due to COVID-19 Public Health Emergency.)*
Administrative Personnel Interviewed:	3 *(Note: Interviews conducted via video / phone due to COVID-19 Public Health Emergency.)*

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Internal Incident Management System Process and Reports
- Personnel Files – including nursing and subcontracted staff
- Staff Training Records, including staff training hours and staff competency reviews
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Cardiopulmonary Resuscitation (CPR) and First Aid Certifications 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 electronically, or 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): **Clovis Homecare, Inc dba Community Homecare**
Program: Medically Fragile Waiver
Service: Home Health Aide (HHA), Private Duty Nursing (PDN), Respite Home Health Aide, Respite Private Duty Nurse - Admin Only – No individuals receiving services at time of survey
Survey Type: Routine
Survey Dates: **June 13 – 24, 2022**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
TAG # MF 1A22 – Agency Personnel Competency			
NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS: A. Duty to report: (1) All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers. (2) All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries, or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. B. Reporter requirement. All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications: (1) Abuse, neglect, and exploitation, suspicious injury, or death reporting: Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by	**Based on interview, the agency did not ensure training competencies were met for 2 of 4 Agency personnel.** **When Agency Personnel were asked; What State Agency do you report to if you suspect any Abuse, Neglect and Exploitation, the following was reported:** • RN Supervisor #503 stated, "notify Program Administrator, Case Manager, CYFD, APS if needed." Staff was not able to identify the State Agency as Division of Health Improvement Incident Management Bureau. **When administrators were asked "What is the Agency's process for completing State Incident Reports as it relates to ANE and other reportable incidents?"** • #502 stated "Agency reports to HSD, NMDOH." *Staff was not able to identify the State Agency as Division of Health Improvement / Incident Management Bureau.* *(Note: The Agency provides other Non-waiver based services to individuals who are regulated under other regulatory entities, such as DHI / HFLC. The Agency was not aware of the Home and Community Based Services Medicaid Waiver*	**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?)*: →	

calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury, or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242. (2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers: In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation, or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us ; otherwise, it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge	*Abuse, Neglect and Exploitation reporting and training requirements, as outlined in NMAC 7.1.14).*		

of the incident participates in the preparation of the report form. (3) Limited provider investigation: No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation. (4) Immediate action and safety planning: Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall: (a) develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable; (b) be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and (c) provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise, it may be submitted by faxing it to the division at 1-800-584-6057. (5) Evidence preservation: The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident. (6) Legal guardian or parental notification: The responsible community-based service provider shall ensure that the consumer's legal guardian			

or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division's investigative representative. (7) Case manager or consultant notification by community-based service providers: The responsible community-based service provider shall notify the consumer's case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation has been reported to the division. Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant. (8) Non-responsible reporter: Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation. D. Incident policies: All community-based service providers shall maintain policies and procedures which describe the community-based service provider's immediate response, including development of an immediate action and safety plan acceptable to the division where appropriate, to all allegations of incidents involving abuse, neglect, or exploitation, suspicious injury as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC. E. Retaliation: Any person, including but not limited to an employee, volunteer, consultant, contractor, consumer, or their family members, guardian, and another provider who, without false intent, reports an incident or makes an allegation of abuse, neglect, or exploitation			

shall be free of any form of retaliation such as termination of contract or employment, nor may they be disciplined or discriminated against in any manner including, but not limited to, demotion, shift change, pay cuts, reduction in hours, room change, service reduction, or in any other manner without justifiable reason. F. Quality assurance/quality improvement program for community-based service providers: The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program: (1) community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements; (2) community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and (3) community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
TAG # MF 1A28.1 Incident Management System – Agency Personnel Training			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **I. PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. C. All providers must be currently enrolled as a MFW provider through the Developmental Disabilities Supports Division (DDSD) Provider Enrollment Unit process: a. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures. b. All provider agencies that enter a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies, and standards. c. Reference: http://dhi.health.state.nm.us/ D. All agencies must follow all applicable DDSD Policies and Procedures. **<u>NMAC 7.1.14.8</u> INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** A. Duty to report: **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical	Based on record review, the Agency did not ensure Incident Management ANE Training for 3 of 3 Agency Personnel. **The following Agency Personnel record(s) contained no evidence of the annual NM DOH Incident Management ANE training was completed for the following:** **Home Health Aide:** • Not Found (#504, 505) **RN Supervisor:** • Not Found (#503) *(Note: The Agency provides other Non-waiver based services to individuals who are regulated under other regulatory entities, such as DHI / HFLC. The Agency was not aware of the Home and Community Based Services Medicaid Waiver Abuse, Neglect and Exploitation reporting and training requirements, as outlined in NMAC 7.1.14). The Agency was additionally not aware of the ANE Awareness Training requirement through DDSD Training Hub).*	**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?)*: →	

services as appropriate to ensure the safety of consumers. **(2)** All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries, or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:** **(1) Abuse, neglect, and exploitation, suspicious injury, or death reporting:** Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury, or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury, or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242.			

(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers: In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation, or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise, it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form. **(3) Limited provider investigation:** No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation. **(4) Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall: **(a)** develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable;			

(b) be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and 4 **(c)** provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise, it may be submitted by faxing it to the division at 1-800-584-6057. **(5) Evidence preservation:** The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident. **(6) Legal guardian or parental notification:** The responsible community-based service provider shall ensure that the consumer's legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division's investigative representative. **(7) Case manager or consultant notification by community-based service providers:** The responsible community-based service provider shall notify the consumer's case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation			

has been reported to the division. Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant. **(8) Non-responsible reporter:** Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation. **D. Incident policies:** All community-based service providers shall maintain policies and procedures which describe the community-based service provider's immediate response, including development of an immediate action and safety plan acceptable to the division where appropriate, to all allegations of incidents involving abuse, neglect, or exploitation, suspicious injury as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC. **E. Retaliation:** Any person, including but not limited to an employee, volunteer, consultant, contractor, consumer, or their family members, guardian, and another provider who, without false intent, reports an incident or makes an allegation of abuse, neglect, or exploitation shall be free of any form of retaliation such as termination of contract or employment, nor may they be disciplined or discriminated against in any manner including, but not limited to, demotion, shift change, pay cuts, reduction in hours, room change, service reduction, or in any other manner without justifiable reason. **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and			

staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **B. Training curriculum:** Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer. **C. Incident management system training curriculum requirements:** **(1)** The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to: **(a)** an overview of the potential risk of abuse, neglect, or exploitation; **(b)** informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse,			

neglect and exploitation, suspicious injury, and all deaths; **(d)** specific instructions on how to respond to abuse, neglect, or exploitation; **(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury. **(2)** All current employees and volunteers shall receive training within 90 days of the effective date of this rule. **(3)** All new employees and volunteers shall receive training prior to providing services to consumers. **D. Training documentation:** All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
TAG # MF103 Continuous Quality Improvement System			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **I. PROVIDER REQUIREMENTS** **A.** The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. **C.** All providers must be currently enrolled as a MFW provider through the Developmental Disabilities Supports Division (DDSD) Provider Enrollment Unit process: a. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures. b. All provider agencies that enter a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies, and standards. c. Reference: http://dhi.health.state.nm.us/ **D.** All agencies must follow all applicable DDSD Policies and Procedures. **III. CONTINUOUS QUALITY MANAGEMENT SYSTEM** A. On an annual basis, MFW provider agencies are required to update and implement the Continuous Quality Improvement Plan. At the time of the DHI audit or upon request, the agency will submit a summary of each year's	Based on record review and interview, the Agency did not maintain or implement a Quality Improvement Plan, as required by standards. **Review of information found:** • No evidence of a Quality Improvement Plan. **When Agency Administrative Personnel were asked if the Agency had a Quality Improvement Committee, who met quarterly and to provide evidence of meeting minutes, the following was reported:** • #500 reported there are no quarterly meetings as the agency meets annually to review satisfaction surveys sent to patients and each manager chooses a project to work on throughout the year. *(Note: Per NMAC <u>7.28.2.39,</u> "To be considered on-going, the quality improvement program must document quarterly activity that addresses, but is not limited to:…")*	**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?)*: →	

quality improvement activities and resolutions to the Provider Enrollment Unit. B. The provider agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and that comply with all DDSD policies and procedures and all relevant New Mexico State statutes, rules, and standards. The agency must review the policies and procedures every three years and update as needed. C. Appropriate planning must take place with all Interdisciplinary Team (IDT) members, Medicaid state plan provider, other waiver providers and school services to facilitate a smooth transition from the MFW Program. The person's choices are given consideration whenever possible DOH policies must be adhered to during this process as per the provider's contract. D. All provider agencies, in addition to requirements under each specific service standard, are required to develop, implement, and maintain, at the designated main agency office, documentation of policies and procedures, for the following: a. Coordination with other provider agency staff serving individuals receiving MFW services that delineates the specific roles of each agency staff. b. Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated. c. Agency protocols for disaster planning and emergency preparedness. **<u>NMAC 7.28.2.39</u> QUALITY IMPROVEMENT:** Each agency must establish an on-going quality improvement program to ensure an adequate and effective operation. To be considered on-going, the quality improvement program must			

document quarterly activity that addresses, but is not limited to: **A. Clinical care:** Assessment of patient/client goals and outcome, such as, diagnosis(es), plan of care, services provided, and standards of patient/client care. **B. Operational activities:** Assessment of the total operation of the agency, such as, policies and procedures, statistical data (i.e., admissions, discharges, total visits by discipline, etc.), summary of quality improvement activities, summary of patient/client complaints and resolutions, and staff utilization. **C. Quality improvement action plan:** Written responses to address existing or potential problems which have been identified. **D. Documentation of activities:** The results of the quality improvement activities shall be compiled annually in report format and formally reviewed and approved by the governing body and advisory group of the home health agency. No more than one year may lapse between evaluations of the same part. **E.** The licensing authority may, at its sole discretion, request quarterly activity summaries of an agency's on-going quality improvement activities or may direct the agency to conduct specific quality improvement studies. [7.28.2.39 NMAC - Rp/E 7 NMAC 28.2.39, 6/5/2020] **Provider Application** New Mexico Department of Health Developmental Disabilities Support Division - Provider Enrollment Unit / Development Disabilities Waiver – Medically Fragile Waiver Revised January 2020 **MF Waiver Authoritative Documents** **21.** Quality Assurance/Quality Improvement Plan			

22. Preparation of the Annual Report; The provider agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency and made available upon request.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
TAG # MF04 General Provider Requirements			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **I. PROVIDER REQUIREMENTS** **A.** The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. **C.** All providers must be currently enrolled as a MFW provider through the Developmental Disabilities Supports Division (DDSD) Provider Enrollment Unit process: a. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures. b. All provider agencies that enter a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies, and standards. c. Reference: http://dhi.health.state.nm.us/ **D.** All agencies must follow all applicable DDSD Policies and Procedures. **E.** All provider agencies that enter in to a contractual relationship with DOH to provide MFW services which comply with all applicable standards herein set forth and are subject to sanctions for noncompliance with the provider agreement and all applicable rules and regulations.	Based on record review and interview, of the Agency's Administrative documentation the Agency did not maintain evidence of all Policies and Procedures which comply with Medically Fragile Waiver Standards and all applicable rules and regulations. **Review of the Agency's Administrative documentation found no evidence of the following Policies and Procedures were reviewed, revised and/or updated at least every three years.** **When the agency was asked for current P & P, the following was reported:** • #500 reported policies were last reviewed in 2016. Policies and procedures reviewed did not indicated the date of last review.	**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?)*: →	

III. CONTINUOUS QUALITY MANAGEMENT SYSTEM B. The provider agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and that comply with all DDSD policies and procedures and all relevant New Mexico State statutes, rules, and standards. The agency must review the policies and procedures every three years and update as needed.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
TAG # MF 1A28 Incident Management System			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **I. PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. C. All providers must be currently enrolled as a MFW provider through the Developmental Disabilities Supports Division (DDSD) Provider Enrollment Unit process: a. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures. b. All provider agencies that enter a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies, and standards. c. Reference: http://dhi.health.state.nm.us/ D. All agencies must follow all applicable DDSD Policies and Procedures. **<u>NMAC 7.1.14.8</u> INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** A. Duty to report: **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical	Based on record review and interview, the Agency did not establish and/or maintain documentation of the Incident Management System for reporting Abuse, Neglect and Exploitation. **Review of the Agency's Policies / Procedures found the following:** • Per the Agency's "NM Incident Management ANE Reporting…Incident Reporting/ANE (Abuse, Neglect, Exploitation)" Policy indicates, **"**Suspected or known Abuse, Neglect & Exploitation will be reported as required by law to appropriate state agencies (e.g., Adult Protective Services, Child Protective Service, Law enforcement, Department of Health)." *Per NMAC 7.1.14 the agency is also required to report the DOH / DHI / IMB.* **When administrators were asked, "How do you ensure all reportable incidents are reported, tracked, and trended", the following was reported:** • #502 stated "Agency logs into Ironline.health.state.nm.us to report the issue, and we follow up with the Clients Care Coordinator, and NMDOH to follow up within five days after the incident has been reported." *Staff was unable to describe how this is done for individuals receiving services under the Medically Fragile Wavier.* **When administrators were asked, "Who provides the Abuse, Neglect & Exploitation (ANE) training", the following was reported:**	**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?)*: →	

services as appropriate to ensure the safety of consumers. **(2)** All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries, or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:** (1) Abuse, neglect, and exploitation, suspicious injury, or death reporting: Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury, or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury, or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242. (2) Use of abuse, neglect, and exploitation or report of death form and notification by	• #500 stated "Primarily we do the annual training through DHI but that's only managers and upper management. Our direct staff do not take that training." *(Note: The Agency provides other Non-waiver based services to individuals who are regulated under other regulatory entities, such as DHI / HFLC. The Agency was not aware of the Home and Community Based Services Medicaid Waiver ANE Awareness Training requirement through DDSD Training Hub).*		

community-based service providers: In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation, or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise, it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form. D. Incident policies: All community-based service providers shall maintain policies and procedures which describe the community-based service provider's immediate response, including development of an immediate action and safety plan acceptable to the division where appropriate, to all allegations of incidents involving abuse, neglect, or exploitation, suspicious injury as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC. F. Quality assurance/quality improvement program for community-based service **providers:** The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or			

exploitation against them as a provider after the division's investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program: **(1)** community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements; **(2)** community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and **(3)** community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.			

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	*No progress notes and billing records were reviewed for the months of March, April, and May of 2022 as the agency is currently not serving any Home and Community Based Services Medically Fragile Waiver individuals.*		

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

DAVID R. SCRASE, M.D.
Acting Cabinet Secretary

Date:	September 16, 2022
To:	Amy Corbin, Executive Director
Provider:	Clovis Homecare, Inc. dba Community Homecare
Address:	1944 West 21st Street
State/Zip:	Clovis, New Mexico 88101
E-mail Address:	corbina@chomecare.biz
CC:	Carol Garrett
E-Mail Address:	cgarrett52@yahoo.com
Region:	Southeast
Survey Dates:	June 13 – 24, 2022
Program Surveyed:	Medically Fragile Waiver (MFW)
Service(s) Surveyed:	***Administrative Review Only.*** At the time of the survey the Agency was not serving any Medically Fragile Waiver Individuals in Home Health Aide (HHA), Private Duty Nursing (PDN), Respite PDN, or Respite
Survey Type:	Routine

Dear Ms. Corbin:

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

Q.22.4.MFW.D0214.4.RTN.09.22.259