NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

(Modified by IRF)

Date:	December 4, 2023
To:	BJ Wilson, Regional Chief Operating Officer
Provider: Address: State/Zip:	Children's Home Healthcare (DJK Home Healthcare LLC) 4600 A Montgomery Blvd. NE, Suite A-101 Albuquerque, New Mexico 87109
E-mail Address:	bj@childrenshha.com
Region: Survey Dates:	Metro and Northeast November 6 – 15, 2023
Program Surveyed:	Medically Fragile Waiver (MFW)
Service(s) Surveyed:	Respite PDN
Survey Type:	Routine
Team Leader:	Jamie Pond, BS, QMB Staff Manager, Division of Health Improvement/Quality Management Bureau
Team Members:	Monica Valdez, BS, Healthcare Surveyor Advanced / Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau; Marie Passaglia, BA, Healthcare Surveyor Advanced, Division of Health Improvement/Quality Management Bureau

Dear Mr. Wilson:

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 # MF1A28.1 Incident Management System – Agency Personnel Training ***(Modified by IRF)***

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, Monica Valdez, Plan of Correction Coordinator** at MonicaE.Valdez@doh.nm.gov

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@hsd.nm.gov*)*

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
5300 Homestead Rd NE, Suite 300-331
Albuquerque, NM 87110
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.

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:	November 6, 2023
Contact:	**Children's Home Healthcare (DJK Home Healthcare LLC)** BJ Wilson, Regional Chief Operating Officer **DOH/DHI/QMB** Jamie Pond, BS, QMB Staff Manager / Team Lead
Entrance Conference Date:	November 6, 2023
Present:	**Children's Home Healthcare (DJK Home Healthcare LLC)** BJ Wilson, Regional Chief Operating Officer Samantha Salsbury, Administrator / Director Brittany Brinlee, BSN, RN, Alternate Supervising Nurse Teresa Bermudez, Regional Office Manager **DOH/DHI/QMB** Jamie Pond, BS, QMB Staff Manager / Team Lead Monica Valdez, BS, Healthcare Surveyor Advanced / POC Coordinator Marie Passaglia, BA, Healthcare Surveyor Advanced **DDSD – Clinical Services Bureau** Alecia Pulu, BSN, RN, Clinical Services Bureau Chief
Exit Conference Date:	November 15, 2023
Present:	**Children's Home Healthcare (DJK Home Healthcare LLC)** BJ Wilson, Regional Chief Operating Officer Samantha Salsbury, Administrator / Director Brittany Brinlee, BSN, RN, Alternate Supervising Nurse Teresa Bermudez, Regional Office Manager Kara Gaut, RN, MSN, Supervising Nurse **DOH/DHI/QMB** Jamie Pond, BS, QMB Staff Manager / Team Lead Monica Valdez, BS, Healthcare Surveyor Advanced / POC Coordinator **DDSD – Clinical Services Bureau** Alecia Pulu, BSN, RN, Clinical Services Bureau Chief
Total Sample Size:	4 4 – Respite Private Duty Nursing
Total Homes Visited:	4
Total Wellness Visits Completed:	2
Recipient Served Records Reviewed:	4
Recipient/Family Members Interviewed:	4
Respite PDN Records Reviewed:	25
Respite PDN Interviewed:	4

RN Supervisor Record(s) Reviewed: 2

RN Supervisor(s) Interviewed: 1

Administrative Personnel Interviewed: 1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Individuals Agency Case Files
- Internal Incident Management System Process and Reports
- Personnel Files – including nursing and subcontracted staff
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- 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

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@doh.nm.gov. 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@doh.nm.gov 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 via email at MonicaE.Valdez@doh.nm.gov. Please also submit your POC to your Developmental Disabilities Supports Division Regional Office for region of service surveyed.
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. You must also submit evidence of the ongoing Quality Assurance/Quality Improvement processes.

1. Your internal documents are due within a *maximum* of 45-business days of receipt of your Report of Findings.
2. Please submit your documents electronically according to the following: If documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to the State email account. If documents contain PHI **do not** submit PHI directly to the State email account. *You may submit PHI*

only *when* ***replying*** *to a* ***secure*** *email received from the State email account*. When possible, please submit requested documentation using a "zipped/compressed" file to reduce file size. You may also submit documents via S-Comm (Therap), or another electronic format, i.e., flash drive.

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 due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

Attachment C

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

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

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB 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: Microsoft Word - IRF-QMB-Form.doc (nmhealth.org)
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@doh.nm.gov for assistance.

The following limitations apply to the IRF process:

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

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

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

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

Agency/Region(s): **Children's Home Healthcare (DJK Home Healthcare LLC) – Metro and Northeast**
Program: Medically Fragile Waiver
Service: Respite Private Duty Nurse
Survey Type: Routine
Survey Dates: **November 6 – 15, 2023**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Personnel Requirements:			
TAG # MF1A28.1 Incident Management System – Agency Personnel Training ***(Modified by IRF)***			
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.	Based on record review and interviews, the Agency did not ensure Incident Management Abuse, Neglect, and Exploitation (ANE) Training for 27 of 27 Agency Personnel. **The following Agency Personnel record(s) contained no evidence of the annual NM DOH DDSD Incident Management ANE training was completed for the following:** **Respite Private Duty Nursing:** • Not Found: #500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526. *(Evidence statement modified by IRF, as the finding did not clearly indicate the DDSD requirement.)* **When Agency Personnel were asked; What State Agency do you report to if you suspect any Abuse, Neglect and Exploitation, the following was reported:** • Respite PDN #518 stated, *"I know where I can find it. (Surveyors asked if she could provide the name or phone number.) She said, "It is in the Pediaconnect." Staff was not*	**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?)*: →	

<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 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	*able to identify the State Agency as Division of Health Improvement or CYFD.* • Respite PDN #519 stated, *"It's on my computer and posted in the home" (Surveyors asked, do you know the agency you report to or have the number?) "No but I know where to find it if I need it." Staff was not able to identify the State Agency as Division of Health Improvement or CYFD.* **When Agency Personnel were asked to give an example of Abuse, Neglect and Exploitation, the following was reported:** • Respite PDN #518 stated, "Treating the person in an unfair manner" for Exploitation.		

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
Medicaid Billing/Reimbursement			
TAG #MF 1A12 All Services Reimbursement (No Deficiencies)			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **VI. DOCUMENTATION** A. Provider agencies must maintain all records necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to individuals who are currently receiving services. The provider agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, level of services, and length of service billed. B. The documentation of the billable time spent with an individual are kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record must contain at least the following information: a. date and start and end time of each service encounter or other billable service interval; b. description of what occurred during the encounter or service interval; and c. signature and title of staff providing the service verifying that the service and time are correct. **<u>RESPITE STANDARDS</u>** **III. REIMBURSEMENT** Each provider agency of a service is responsible for developing clinical documentation that identifies the direct support	Based on record review, the Agency maintained all the records necessary to fully disclose the nature, quality, amount, and medical necessity of services furnished to an eligible recipient who is currently receiving Respite Private Duty Nursing for 4 of 4 Individuals served. *Progress notes and billing records supported billing activities for the months of July, August, and September 2023.*		

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

PATRICK M. ALLEN
Cabinet Secretary

Date:	December 20, 2023
To:	BJ Wilson, Regional Chief Operating Officer
Provider:	Children's Home Healthcare (DJK Home Healthcare LLC)
Address:	4600 A Montgomery Blvd. NE, Suite A-101
State/Zip:	Albuquerque, New Mexico 87109
E-mail Address:	bj@childrenshha.com
Region:	Metro and Northeast
Survey Dates:	November 6 – 15, 2023
Program Surveyed:	Medically Fragile Waiver (MFW)
Service(s) Surveyed:	Respite PDN
Survey Type:	Routine

Dear Mr. Wilson:

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved your Plan of Correction.

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, including:

- Utilizing the CDD-UNM Waiver Training Hub for NM DOH Incident Management ANE training for agency personnel.

Consistent use of these Quality Assurance processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies cited in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, for striving to come into compliance with standards and regulations, and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,

Monica Valdez, BS

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

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