NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date:	June 3, 2024
To:	Jamie Ortega, Owner / Director
Provider: Address: State/Zip:	Hearts of Hope, LLC 1065 South Main Street, Bldg. D – Suite H Las Cruces, New Mexico 88005
E-mail Address:	jamie@heartsofhopellc.net
CC: E-Mail Address:	Scott Barela scott@heartsofhopellc.net
Region: Survey Date:	Southwest April 22 – May 3, 2024
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Supported Living, Family Living, Customized In-Home Supports, and Customized Community Supports
Survey Type:	Routine
Team Leader:	Heather Driscoll, AA, Division of Health Improvement/Quality Management Bureau
Team Members:	Novae Bernal, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Amanda Castaneda – Holguin, MPA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Joel Gonzalez, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Tania Guerra, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jessica Maestas, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Verna Newman – Sikes, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau;

Dear Mr. Jamie Ortega.

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Determination of Compliance:

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

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 # 1A25.1 Caregiver Criminal History Screening
- Tag # 1A09 Medication Delivery Routine Medication Administration
- Tag # 1A09.1 Medication Delivery PRN Medication Administration
- Tag # 1A31 Client Rights / Human Rights

The following tags are identified as Standard Level:

- 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 # 1A32.2 Individual Service Plan Implementation (Residential Implementation)
- Tag # 1A26 Employee Abuse Registry
- Tag # 1A37 Individual Specific Training
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A33.1 Board of Pharmacy – License
- Tag # 1A39 Assistive Technology and Adaptive Equipment
- Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)
- Tag # IS30 Customized Community Supports Reimbursement
- Tag # LS26 Supported Living Reimbursement
- Tag # LS27 Family Living 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, Monica Valdez, Plan of Correction Coordinator** at MonicaE.Valdez@doh.nm.gov

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
PO Box 2348
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.

Please contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@doh.nm.gov 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:	April 22, 2024
Contact:	**Hearts of Hope, LLC** Jamie Ortega, Owner / Director **DOH/DHI/QMB** Heather Driscoll, AA, Team Lead/Healthcare Surveyor
Entrance Conference Date:	April 22, 2024
Present:	**Hearts of Hope, LLC** Scott Barela, Service Coordinator / Office Manager Maryann Flores, Billing Specialist Virginia Flores, Service Coordinator Supervisor Debbie Gonzalez, Co - Owner / Nurse Supervisor Minerva Maese, Agency Trainer Jamie Ortega, Owner / Director **DOH/DHI/QMB** Heather Driscoll, AA, Team Lead/Healthcare Surveyor Amanda Castaneda – Holguin, MPA, Healthcare Surveyor Supervisor Tania Guerra, BA, Healthcare Surveyor Verna Newman – Sikes, AA, Healthcare Surveyor
Exit Conference Date:	May 3, 2024
Present:	**Hearts of Hope, LLC** Scott Barela, Service Coordinator / Office Manager Virginia Flores, Service Coordinator Supervisor Minerva Maese, Agency Trainer Jamie Ortega, Owner / Director **DOH/DHI/QMB** Heather Driscoll, AA, Team Lead/Healthcare Surveyor Novae Bernal, BA, Healthcare Surveyor Amanda Castaneda – Holguin, MPA, Healthcare Surveyor Supervisor Joel Gonzalez, Healthcare Surveyor Tania Guerra, BA, Healthcare Surveyor Sally Karingada, BS, Healthcare Surveyor Supervisor Jessica Maestas, Healthcare Surveyor Verna Newman – Sikes, AA, Healthcare Surveyor
Administrative Locations Visited:	0 *(Administrative portion of survey completed remotely)*
Total Wellness Visits Completed (Individuals Seen):	28
Total Compliance Survey Sample Size:	15 7 - Supported Living 6 - Family Living 2 - Customized In-Home Supports 14 - Customized Community Supports
Total Compliance Survey Homes Visits	12

❖ Supported Living Homes Visited	5 *Note: The following Individuals share a SL residence:* • #1, 4 • #6, 12
❖ Family Living Homes Visited	5 *Note: The following Individuals share a FL residence:* • #7, 8
❖ Customized In-Home Support Home Visited	2
Persons Served Records Reviewed	15
Persons Served Interviewed	13
Persons Served Observed	2 *(Note: Two individuals were observed, as the individuals chose not to participate in the interview process)*
Direct Support Professional Records Reviewed	106
Direct Support Professional Interviewed	21
Service Coordinator Records Reviewed	6
Nurse Interview	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Oversight of Individual Funds
- Individual Agency / Residential / Site Case Files, including, but not limited to:
    - Individual Service Plans
    - Progress on Identified Outcomes
    - Healthcare Plans
    - Medication Administration Records
    - Physician Orders
    - Therapy Plans
    - Healthcare Documentation Regarding Appointments and Required Follow-Up
    - Other Required Health Information / Therap Required Documents
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files:
    - Training Records
    - Caregiver Criminal History Screening Records
    - Consolidated Online Registry/Employee Abuse Registry
- Interviews with the Individuals and Agency Personnel
- Human Rights Committee Notes and Meeting Minutes
- Quality Assurance / Improvement Plan
- Agency Policy and Procedure Manual

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
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.

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 ensure 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 respective Regional DDSD Office.
4. Submit your POC to via email to 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 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 Professional 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)
- **1A09.2 –** Medication Delivery Nurse Approval for PRN Medication

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
- **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: 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.

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.					

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 # 1A08.1 Administrative and Residential Case File: Progress Notes	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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: … 5. 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. 6. 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. 7. The current Client File Matrix found in Appendix A: Client File Matrix details the minimum requirements for records to be	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 10 of 15 Individuals. Review of the Agency administrative individual case files revealed the following items were not found and/or did not meet the requirement: **Administrative Case File:** **Supported Living Progress Notes/Daily Contact Logs:** • Individual #1 - None found for 3/30/2024. • Individual #3 - None found for 2/4/2024. • Individual #6 - None found for 3/13, 14, 15, 23, 2024. **Family Living Progress Notes/Daily Contact Logs:** • Individual #7 - None found for 3/18/2024. • Individual #8 - None found for 3/18/2024. **Residential Case File:** **Supported Living Progress Notes/Daily Contact Logs:** • Individual #3 - None found for 4/23/2024. *(Date of home visit: 4/24/2024)*	**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?)*: →	

stored in agency office files, the delivery site, or with DSP while providing services in the community.	• Individual #5 - None found for 4/17, 19, 2024. *(Date of home visit: 4/22/2024)* • Individual #6 - None found for 4/1 – 23, 2024. *(Date of home visit: 4/24/2024)* • Individual #11 - None found for 4/1 – 22, 2024. *(Date of home visit: 4/23/2024)* • Individual #12 - None found for 4/1 – 23, 2024. *(Date of home visit: 4/24/2024)* **Family Living Progress Notes/Daily Contact Logs:** • Individual #2 - None found for 4/1 – 24, 2024. *(Date of home visit: 4/25/2024)* • Individual #8 - None found for 4/24/2024. *(Date of home visit: 4/25/2024)* • Individual #15 - None found 4/1 – 7, 15 – 23, 2024. *(Date of home visit: 4/24/2024)*		

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 support 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 purpose in planning for individuals with	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 15 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Customized in Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #14 • None found regarding: Live Outcome/Action Step: "Natural supports will assign household chore to…" for 2/2024. Action step is to be completed 3 times per week. • None found regarding: Live Outcome/Action Step: "…will complete his household chore" for 2/2024. Action step is to be completed 3 times per week. **Customized Community Supports Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #11 • None found regarding: Work/Learn Outcome/Action Step: "Continue GED courses and tests for progress" for 1/2024 – 2/2024. Action step is to be completed 3 times per week. *Note: Document maintained by the provider was blank.*	**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?)***:** →	

developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 6: 6.10 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) … 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: … 6. 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. 7. 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.			

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 support 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 5 of 15 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 prepare 7 meals for the week" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2024. Individual #6 • According to the Live Outcome, Action Step for "Learn safety skills" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2024. • According to the Live Outcome, Action Step for "Choose and make a recipe" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2024. **Family Living Data Collection / Data Tracking/Progress with regards to ISP Outcomes:**	**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 Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 6: 6.10 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) … 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: … 6. 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. 7. 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,	Individual #2 • According to the Live Outcome, Action Step for "…will search for recipes" 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 3/2024. • According to the Live Outcome, Action Step for "…will cook selected meal / recipe" 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 3/2024. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #3 • According to the Health Outcome, Action Step for "…will go bowling" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2024. Individual #6 • According to the Fun Outcome, Action Step for "…will do her schedule weekly" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2024. Individual #7 • According to the Fun Outcome, Action Step for "…will choose a community activity" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2024.		

or with DSP while providing services in the community.	• According to the Fun Outcome, Action Step for "…will participate in his chosen activity" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2024. Individual #11 • According to the Work/Learn Outcome, Action Step for "Continue GED Courses and tests for progress." is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2024.		

Tag # 1A32.2 Individual Service Plan Implementation (Residential 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 residential 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 13 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 #11 • None found regarding: Live Outcome/Action Step: “Exercise at chosen area” for 4/1 – 19, 2024. Action step is to be completed 3 times per week. (Date of home visit: 4/23/2024) **Family Living Data Collection/Data Tracking / Progress with regards to ISP Outcomes:** Individual #15 • None found regarding: Live Outcome/Action Step: “FLP will show her how many minutes to warm the food” for 4/1 – 19, 2024. Action step is to be completed 2 times per week. (Date of home visit: 4/23/2024) • None found regarding: Live Outcome/Action Step: “...will then try to add the numbers to the microwave to warm up the food” for 4/1 – 19, 2024. Action step is to be completed 2 times per week. (Date of home visit: 4/23/2024)	**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 Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 6: 6.10 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) … 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: … 6. 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. 7. 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.			

Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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. Records must contain information of concerns related to abuse, neglect, or exploitation. 3. 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. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. 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,	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 7 of 13 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, not current and/or did not meet the requirement: **ISP Teaching and Support Strategies:** ***Individual #6:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "Learn safety kitchen skills." ***Individual #12:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "…will wash a load of laundry." • "…will dry a load of laundry." **Healthcare Passport:** • Not Found (#9, 11) **Comprehensive Aspiration Risk Management Plan:** • Not Found (#7) **Health Care Plans:** • Body Mass Index (#3) • Skin and Wound (#5)	**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?)*: →	

progress notes, and any other interactions for which billing is generated. 6. 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. 7. 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. **20.3 Record Access for Direct Support Professionals (DSP) during Service Delivery:** DSP must have access to records, plans, and forms needed to adequately provide and document the type of service and specific scope of service being provided at the time. **20.5 Communication and Documentation in Therap:** Therap is a secure online documentation system required to be used by specific New Mexico DD Waiver Provider Agencies. Use of the required elements of Therap are intended to improve agency monitoring, health care coordination for individuals, and overall quality of services. **20.5.3 *Health Passport and Consultation Form*** **20.5.4 *Health Tracking*** **20.5.5 *Nursing Assessment Tracking*** **Chapter 13 Nursing Services: 13.2.9.1 Health Care Plans (HCP):** Health Care Plans are created to provide guidance for the Direct Support Professionals (DSP) to support health related issues. Approaches that are specific to nurses may also be incorporated into the HCP.			

Healthcare Plans are based upon the eCHAT and the nursing assessment of the individual's needs. 1. The Primary Provider Agency nurse (PPN) 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 that the nurse determines are warranted.			

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 Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 17 Training Requirements:** **17.9 Individual-Specific Training Requirements:** 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 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. The trainer must 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	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 10 of 21 Direct Support Professional. **When DSP were asked, if they knew what the Individual's health condition / diagnosis or when the information could be found, the following was reported:** • DSP #565 stated, "Seizures, Hypothyroidism, Allergies, Hiatal Hernia, Psoriasis, and Cerebral Palsy." Per Electronic Comprehensive Health Assessment Tool, the Individual does not have a diagnosis of Cerebral Palsy. According to the Electronic Comprehensive Assessment Tool, the Individual also has a diagnosis of Down Syndrome. (Individual #9) **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 #583 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Body Mass Index, Falls, and Status of Care / Hygiene. (Individual #1)	**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?)*: →	

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…	• DSP #601 stated, "BMI, GERD, Constipation, Status of Care / Hygiene, Oral Care." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for Falls. (Individual #1) • DSP #541 stated, "Oral hygiene, diabetes, skin integrity." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for Body Mass Index. (Individual #3) • DSP #551 stated, "He has Skin, Obesity, Aspiration Risk. I think that is it." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for Respiratory. (Individual #4) • DSP #503 stated, "BMI, Aspiration Risk, Impaired skin integrity for picking." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for Respiratory. (Individual #4) • DSP #594 stated, "Yes, to make sure he eats well, exercise." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Seizure Disorder. (Individual #7) **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 #547 stated, "Not that I know." As indicated by the Electronic Comprehensive Health Assessment Tool, the individual is allergic to apples. (Individual #2)		

	• DSP #547 stated, "No, just the latex." As indicated by the Electronic Comprehensive Health Assessment Tool, the individual is also allergic to Morphine. (Individual #4) • DSP #549 stated, "No, he does not." As indicated by the Electronic Comprehensive Health Assessment Tool, the individual is allergic to Gluten and Penicillin. (Individual #7) • DSP #549 stated, "No, he got a penicillin shot – no. I don't think he is because they gave him a penicillin shot for his syphilis. That happened when he was young. He isn't allergic to Penicillin." As indicated by the Electronic Comprehensive Health Assessment Tool, the individual is allergic to Penicillin. (Individual #8) • DSP #565 stated, "No allergies. Well, he was allergic to the flu shot, and they did stop giving it to him, but nothing else." As indicated by the Electronic Comprehensive Health Assessment Tool the individual is allergic to Lamisil Methotrexate, Otezla, and Sulfamethazine. (Individual #9) **When DSP were asked, if the Individual had Seizure Disorder, as well as a series of questions specific to the DSP's knowledge of the Seizure Disorder, the following was reported:** • DSP #594 stated, "He does not." As indicated by the Individual Specific Training section of the ISP, Residential and Day staff are required to receive training. (Individual #7) **When DSP were asked, what are the steps you need to take before assisting an**		

	individual with PRN medication, the following was reported: • DSP #598 stated, "I let him know, I prompt him, and I ask him if he is sick. He takes his med and then washes his hands." Per DDSD standards DSP not related to the Individual must contact nurse prior to assisting with medication. (Individual #13)		

Tag # 1A25.1 Caregiver Criminal History Screening	Condition of Participation Level Deficiency		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **A. General:** The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers, and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978 (Amended) of the act, a care provider's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider] to impose appropriate administrative sanctions and penalties. **B. Exception:** A caregiver or hospital caregiver applying for employment or contracting services with a care provider within twelve (12) months of the caregiver's or hospital caregiver's most recent nationwide criminal history screening which list no disqualifying convictions shall only apply for a statewide criminal history screening upon offer of employment or at the time of entering into a contractual relationship with the care provider. At the discretion of the care provider a nationwide criminal history screening, additional to the required statewide criminal history screening, may be requested. **C. Conditional Employment:** Applicants, caregivers, and hospital caregivers who have	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 indicating Caregiver Criminal History Screening was completed as required for 1 of 112 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** **Direct Support Professional (DSP):** • #534 – Date of hire 2/10/2023.	**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?)*: →	

submitted all completed documents and paid all applicable fees for a nationwide and statewide criminal history screening may be deemed to have conditional supervised employment pending receipt of written notice given by the department as to whether the applicant, caregiver or hospital caregiver has a disqualifying conviction. **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **G. Maintenance of Records:** Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver, or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:**			

A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver, or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide. **B.** trafficking, or trafficking in controlled substances. **C.** kidnapping, false imprisonment, aggravated assault, or aggravated battery. **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses. **E.** crimes involving adult abuse, neglect, or financial exploitation. **F.** crimes involving child abuse or neglect. **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection. Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 16 Qualified Provider Agencies:** **16.1 Caregivers Criminal History Screening Program:** The Caregivers Criminal History Screening Program (CCHSP) is essential to the enforcement of the DOH policy of "Zero Tolerance" of Abuse, Neglect and Exploitation (ANE) and to the DHI mission of enhancing the quality of health systems for all New Mexicans… 1. For the purposes of the DD Waiver, the CCHSP applies to any non-licensed person			

whose employment, contractual or volunteer service with a DD Waiver Provider Agency includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that Provider Agency including: a. DSP, Direct Support Supervisors and Service Coordinators for CCS, CIE, Respite, CIHS, and Living Supports (Family Living, Supported Living, and IMLS). b. any unlicensed CMs. c. administrators or operators of facilities who are routinely on site where support is provided. d. any unlicensed providers of SSE; and e. any compensated persons such as employees, contractors, volunteers, and employees of contractors. 2. All non-licensed personnel must obtain a caregiver criminal history screening background check within 20 calendar days of hire (NMAC7.1.9). Provider Agencies must also check the EAR prior to hiring or contracting with an employee (NMAC 7.1.12). 3. Individuals with a disqualifying criminal conviction or who have been placed on the EAR for a substantiation of ANE are not eligible to work as a caregiver or have access to patient/client/resident information or records.			

Tag # 1A26 Employee Abuse Registry	Standard Level Deficiency		
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain, and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to search the registry reasonably and completely, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry.	Based on record review, the Agency did not maintain documentation in the employees' personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 1 of 112 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Professional (DSP):** • #534 – Date of hire 2/10/2023, completed 2/28/2023.	**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?)*: →	

D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidence the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect, or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.			

Tag # 1A37 Individual Specific Training	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 17 Training Requirements: 17.1 Training Requirements for Direct Support Professional and Direct Support Supervisors:** Direct Support Professional (DSP) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports… The training shall address at least the following: • Individual Specific Training **17.1.13 Training Requirements for Service Coordinators (SC):** Service Coordinators (SCs) refer to staff at agencies providing the following services: Supported Living, Family Living, Customized In-home Supports, Intensive Medical Living, Customized Community Supports, Community Integrated Employment, and Crisis Supports…The training shall address at least the following: • Individual Specific Training **17.9 Individual-Specific Training Requirements:** 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… 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…	Based on interview, the Agency did not ensure that Individual Specific Training requirements were met for 1 of 112 Agency Personnel. Review of personnel records found no evidence of the following: **When DSP were asked, if they were provided with Individual Specific Training for the Individual they are supporting, the following was reported:** • DSP #588 stated, "The CPI, CPR. I had to do a lot of paperwork. I can't think of that right now." (Individual #2)	**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?)*: →	

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 Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 3 Safeguards: 3.1 Decisions about Health Care or Other Treatment: Decision Consultation Process:** There are a variety of approaches and available resources to support decision making when desired by the person. The decision consultation process assists participants and their health care decision makers to document their decisions. It is important for provider agencies to communicate with guardians to share with the Interdisciplinary Team (IDT) Members any medical, behavioral, or psychiatric information as part of an individual's routine medical or psychiatric care. **3.1.1 Decision about Health Care or Other Treatment Decision Consultation:** Decisions are the sole domain of waiver participants; their guardians or healthcare decision makers and decisions can be made that are compatible with their personal and cultural values. Provider Agencies and Interdisciplinary Teams (IDTs) are required to support the informed decisions made by supporting access to medical consultation, information, and other available resources according to the following: The Decision Consultation Process (DCP) is documented on the Decision Consultation Form (DCF) and is used for recommendations when a person or his/her guardian/healthcare decision maker has concerns, needs more information, or has decided not to follow all or part of a recommendation from a professional or clinician…	Based on record review the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 1 of 15 individuals receiving Living Care Arrangements and Community Inclusion. Review of the Agency administrative individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Annual Physical *(LCA Only)*:** • Not Found (#13)	**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?)*: →	

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. Records must contain information of concerns related to abuse, neglect or exploitation. 3. 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. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. 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. 6. 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. 7. 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. 8. All records must be retained for six (6) years 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 Communication and Documentation in Therap:** Therap is a secure online documentation system required to be used by specific New Mexico DD Waiver Provider Agencies. Use of the required elements of Therap are intended to improve agency monitoring, health care coordination for individuals, and overall quality of services. **20.5.3 *Health Passport and Consultation Form:*** The Health Passport and Consultation form are generated within Therap. The standardized combination of documents includes all information that are required for medical consultation during an appointment and other health coordination activities: 1. The Primary Provider must keep the Health Passport and Consultation form updated in concert with critical information and changes from the IDT, including secondary provider agencies, medical providers for the individual. The Health Passport pulls from Individual Demographics, Health Tracking and eCHAT. a. The primary provider must notify secondary providers when a new eCHAT is completed or contact information is updated. 2. The Primary and Secondary Provider Agencies must ensure that a current copy of the *Health Passport* and *Consultation* forms			

are printed and available at all service delivery sites. a. Updated forms must be sent to each site after eCHAT and/or Contact Updates. b. Outdated version of both unused forms must be removed from all sites. 3. Primary and Secondary Provider Agencies must assure that the current *Health Passport* and *Consultation* form accompany each person when taken by the provider to a medical appointment, urgent care/emergency room visits, emergency service encounter, or are admitted to a hospital or nursing home for details see Health Tracking: Appointments **20.5.4 *Health Tracking*** **20.5.5 *Nursing Assessment Tracking*** **Chapter 13 Nursing Services: 13.2.3 General Requirements Related to Orders, Implementation, and Oversight:** 1. Each person has a licensed primary care practitioner and receives an annual physical examination, dental care and specialized medical/behavioral care as needed. PPN communicates with providers regarding the person as needed. 2. Orders from licensed healthcare providers are implemented promptly and carried out until discontinued. a. The nurse will contact the ordering or on call practitioner as soon as possible if the order cannot be implemented due to the person's or guardian's refusal or due to other issues delaying implementation of the order. The nurse must clearly document the issues and all attempts to resolve the problems with all involved parties. b. Not implementing orders by a licensed healthcare provider is considered neglect, unless a Decision Consultation Form is filled out by participant or guardian, or a healthcare decision maker making this decision.			

c. Based on prudent nursing practice, if a nurse determines to hold a practitioner's order, they are required to immediately document the circumstances and rationale for this decision and to notify the ordering or on call practitioner as soon as possible, but no later than the next business day. d. If the person resides with their biological family, and there are no nursing services budgeted, the family is responsible for implementation or follow up on all orders from all providers.			

Tag # 1A09 Medication Delivery Routine Medication Administration	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 10 Living Care Arrangements (LCA): 10.3.5 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 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 5.7 Medication Administration Record (MAR) **Chapter 20 Provider Documentation and Client Records: 20.5.7 Medication Administration Record (MAR):** Administration of medications apply to all provider agencies of the following services: living supports, customized community supports, community integrated employment, intensive medical living supports. 1. Primary and secondary provider agencies are to utilize the Medication Administration Record (MAR) online in Therap. 2. Medication/Treatment must be recorded online per assisting with medication delivery per the DDSD Assisting with Medication Delivery (AWMD) program. 3. Family Living Providers may opt not to use MARs if they are the **sole** provider who supports the person and are related by affinity or consanguinity. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, a MAR online in Therap must be created and used by the DSP. 4. Provider Agencies must configure and use the MAR when assisting with medication.	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 March and April 2024 Based on record review, 4 of 8 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #5 April 2024 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Amantadine 100mg (1 time daily) – Blank 4/9 (9:00 AM) • Absorbic Acid 500mg (2 times daily) – Blank 4/9 (9:00 AM), 4/13,18 (8:00 PM) • Aspirin 81mg (1 time daily) – Blank 4/9 (9:00 AM) • Atorvastatin Calcium 20mg (1 time daily) – Blank 4/13, 18 (9:00 AM) • B-Complex (2 times daily) – Blank 4/9 (9:00 AM), 4/13,18 (8:00 PM) • Baclofen 100mg (2 times daily) – Blank 4/9 (9:00 AM), 4/13,18 (8:00 PM) • Benztropine 2mg (2 times daily) – Blank 4/9 (9:00 AM), 4/13,18 (8:00 PM)	**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?)*: →	

5. Provider Agencies Continually communicate any changes about medications and treatments between Provider Agencies to assure health and safety. 6. Provider agencies must include 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 and PRN medications and other treatments; all over the counter (OTC) or "comfort" medications or treatments; all self-selected herbal preparation approved by the prescriber, and/or vitamin therapy approved by prescriber. c. Documentation of all, time limited or discontinued medications or treatments. d. The initials of the person administering or assisting with medication delivery. e. Documentation of refused, missed, or held medications or treatments. f. Documentation of any allergic reaction that occurred due to medication or treatments. g. For PRN medications or treatments including all physician approved over the counter medications and herbal or other supplements: 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 follow-up detailed documentation that the DSP contacted the agency nurse or physician service prior to assisting with the medication or treatment; and	• Cetirizine Hydrochloride (1 time daily) – Blank 4/9 (9:00 AM) • Depakote DR CP Sprinkle 125mg (2 times daily) – Blank 4/9 (9:00 AM), 4/13, 18 (8:00 PM). • Docusate Sodium 100mg (1 time daily) – Blank 4/9 (9:00 AM) • Entresto F/C 24mg/26mg (2 times daily) – Blank 4/9 (9:00 AM), 4/13,18 (8:00 PM) • Farxiga 10mg (1 time daily) – Blank 4/9, 10 (9:00 AM) • Fluticasone 50mcg (1 time daily) – Blank 4/9 (9:00 AM) • Glipizide ER 5mg (1 time daily) – Blank 4/9 (8:00 AM) • Levothyroxine 75mcg (1 time daily) – Blank 4/9 (6:00 AM) • Lorazepam 0.5mg (2 times daily) – Blank 4/9 (9:00 AM), 4/13,18 (8:00 PM) • Metformin HCL 100mg (2 times daily) – Blank 4/9 (9:00 AM), 4/13,18 (8:00 PM) • Metoprolol Succinate ER 200mg (1 time daily) – Blank 4/9 (8:00 AM) • Mirtazapine 15mg (1 time daily) – Blank 4/13,18 (8:00 PM) • Paliperidone ER 3mg (1 time daily) – Blank 4/13,18 (8:00 PM) • Prasugrel 10mg (1 time daily) – Blank 4/9 (9:00 AM)		

iii. documentation of the effectiveness of the PRN medication or treatment. **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 detailed 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.	• Quetiapine Fumarate 300mg (1 time daily) – Blank 4/9 (9:00 AM) • Vitamin D3 1000Units (1 time daily) – Blank 4/9, 12 (9:00 AM) • Vitamin E 400units (1 time daily) – Blank 4/9 (9:00 AM) Individual #6 April 2024 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Lamisil AT 1% (1 time daily) – Blank 4/23 (8:00 PM) Individual #11 March 2024 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Ketoconazole 2% (2 times weekly) Individual #13 April 2024 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Aspril EC 81mg (1 time daily) – Blank 4/25 (7:00 AM) • Atorvastatin Calcium 10mg (1 time daily) – Blank 4/24 (8:00 PM) • Calcium 500-Vit D3 500mg (1 time daily) – Blank 4/25 (8:00 AM) • Doxazosin Mesylate 4mg (1 time daily) – Blank 4/25 (8:00 AM)		

	• Famotidine 20mg (1 time daily) – Blank 4/25 (8:00 AM) • Quetiapine ER 50mg (1 time daily) – Blank 4/25 (8:00 AM)		

Tag # 1A09.1 Medication Delivery PRN Medication Administration	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 10 Living Care Arrangements (LCA): 10.3.5 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 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 5.7 Medication Administration Record (MAR) **Chapter 20 Provider Documentation and Client Records: 20.5.7 Medication Administration Record (MAR):** Administration of medications apply to all provider agencies of the following services: living supports, customized community supports, community integrated employment, intensive medical living supports. 1. Primary and secondary provider agencies are to utilize the Medication Administration Record (MAR) online in Therap. 2. Medication/Treatment must be recorded online per assisting with medication delivery per the DDSD Assisting with Medication Delivery (AWMD) program. 3. Family Living Providers may opt not to use MARs if they are the **sole** provider who supports the person and are related by affinity or consanguinity. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, a MAR online in Therap must be created and used by the DSP. 4. Provider Agencies must configure and use the MAR when assisting with medication.	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 March and April 2024. Based on record review, 5 of 8 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #1 March 2024 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • 8-Hour Arthritis Pain ER 600mg (PRN) • Anti – Diarrheal 2mg (PRN) • Mucus Relief 600mg (PRN) • Olopatadine HCL 0.2% (PRN) • Polyethylene Glycol 3350 (PRN) • Zyrtec 10mg (PRN) • Zinc Oxide Cream (PRN) April 2024 As indicated by the Medication Administration Records the following medication is to be taken, however was not found in the home: • 8-Hour Arthritis Pain ER 650mg (PRN) • Dicyclomine 20mg (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?)*: →	

5. Provider Agencies Continually communicate any changes about medications and treatments between Provider Agencies to assure health and safety. 6. Provider agencies must include 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 and PRN medications and other treatments; all over the counter (OTC) or "comfort" medications or treatments; all self-selected herbal preparation approved by the prescriber, and/or vitamin therapy approved by prescriber. c. Documentation of all, time limited or discontinued medications or treatments. d. The initials of the person administering or assisting with medication delivery. e. Documentation of refused, missed, or held medications or treatments. f. Documentation of any allergic reaction that occurred due to medication or treatments. g. For PRN medications or treatments including all physician approved over the counter medications and herbal or other supplements: 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 follow-up detailed documentation that the DSP contacted the agency nurse or physician service prior to assisting with the medication or treatment; and	• Olopatadine HCL 0.2% (PRN) • Ondansetron 4mg (PRN) • Polyethylene Glycol 3350 (PRN) • Zyrtec 10mg (PRN) Individual #3 March 2024 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Ibuprofen 800mg (PRN) • Loperamide 2mg (PRN) • Meloxicam 15mg (PRN) April 2024 As indicated by the Medication Administration Records the following medication is to be taken, however was not found in the home: • Dicyclomine 20mg (PRN) • Meloxicam 15mg (PRN) • Nystatin 100,000 unit/gm (PRN) • Triamcinolone 0.1% (PRN) Individual #4 March 2024 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Acetaminophen 500mg (PRN) • Albuterol HFA 90mcg (PRN)		

iii. documentation of the effectiveness of the PRN medication or treatment. **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 detailed 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.	• Hydroxyzine HCL 50mg (PRN) • Loperamide 2mg (PRN) April 2024 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Mucus Relief ER 600mg – PRN – 4/12, 15 (given 1 time) As indicated by the Medication Administration Records the following medication is to be taken, however was not found in the home: • Albuterol HFA 90mcg (PRN) • Hydroxyzine HCL 50mg (PRN) • Ondansetron ODT 8mg (PRN) • Prochlorperazine 10mg (PRN) Individual #5 March 2024 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Cough Drops (PRN) • Sore Throat Spray (PRN) April 2024 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 325mg – PRN – 4/16 (given 1 time) As indicated by the Medication Administration Records the following		

	medication is to be taken, however was not found in the home: • Ipratropium Bromide 42mcg (0.06%) Individual #12 March 2024 Physician's Orders indicated the following medication was to be given. The following Medications <u>were not documented on the Medication Administration Records</u>: • Hydrocortisone 1% (PRN)		

Tag # 1A31 Client Rights / Human Rights	Condition of Participation Level Deficiency		
NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 2 Human Rights:** Civil rights apply to everyone including all waiver participants. Everyone including family members, guardians, advocates, natural supporters, and Provider Agencies have a responsibility to make sure the rights of persons receiving services are not violated. All Provider Agencies play a role in person-centered planning (PCP) and have an obligation to contribute to the planning process, always focusing on how to	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 ensure the rights of Individuals were not restricted or limited for 3 of 15 Individuals. <u>No documentation</u> was found regarding Human Rights Approval for the following: • Locked Television Remote. - No evidence found of Human Rights Committee approval. (Individual #3) • Staff review of Cell Phone and Internet Browsing History every 15 Minutes. - No evidence found of Human Rights Committee approval. (Individual #4) • Staff Presence in Bathroom / Dressing Room. - No evidence found of Human Rights Committee approval. (Individual #5) • Use of 911. - No evidence found of Human Rights Committee approval. (Individual #4) • Staff Supervision while Shaving. - No evidence found of Human Rights Committee approval. (Individual #5)	**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?)***:** →	

best support the person and protecting their human and civil rights. ***2.2*** **Home and Community Based Services (HCBS): Consumer Rights and Freedom:** People with I/DD receiving DD Waiver services, have the same basic legal, civil, and human rights and responsibilities as anyone else. Rights shall never be limited or restricted unnecessarily, without due process and the ability to challenge the decision, even if a person has a guardian. Rights should be honored within any assistance, support, and services received by the person. **Chapter 3 Safeguards: 3.4.5 Interventions Requiring HRC Review and Approval:** HRCs must review any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies that include a restriction of an individual's rights; this HRC should occur prior to implementation of the strategy or strategies proposed. Categories requiring an HRC review include, but are not limited to, the following: 1. response cost (See the BBS Guidelines for Using Response Cost). 2. restitution (See BBS Guidelines for Using Restitution). 3. emergency physical restraint (EPR). 4. routine use of law enforcement as part of a BCIP. 5. routine use of emergency hospitalization procedures as part of a BCIP. 6. use of point systems. 7. use of intense, highly structured, and specialized treatment strategies, including levels systems with response cost or failure to earn components. 8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons. 9. use of PRN psychotropic medications.			

10. use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey gloves for biting hand). 11. use of bed rails. 12. use of a device and/or monitoring system through RPST may impact the person's privacy or other rights; or 13. use of any alarms to alert staff to a person's whereabouts.			

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 Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 16 Qualified Provider Agencies:** **16.5 Board of Pharmacy:** All DD Waiver Provider Agencies with service settings where medication administration/assistance to two or more unrelated individuals occurs must be licensed by the Board of Pharmacy and must follow all Board of Pharmacy regulations related to medication delivery including but not limited to: 1. pharmacy licensing. 2. medication delivery. 3. proper documentation and storage of medication. 4. use of a pharmacy policy manual; and 5. holding an active contract with a Pharmacy Consultant.	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 10 residences: **Individual Residence:** • Current Custodial Drug Permit from the NM Board of Pharmacy with the current address of the residence (#1, 4) *Note: The following Individuals share a residence:* • #1, 4 • #6, 12 • #7, 8	**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 # 1A39 Assistive Technology and Adaptive Equipment	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 12 Professional and Clinical Services: 12.5.1 Participatory Approach:** The "Participatory Approach" is person-centered and asserts that no one is too severely disabled to benefit from assistive technology and other therapy supports that promote participation in life activities… **12.5.7.3 Assistive Technology (AT) Services, Remote Personal Support Technology (RPST) and Environmental Modifications:** Therapists support the person to access and utilize AT, RPST and Environmental Modifications through the following requirements: … 2. Therapists are required to provide a current AT Inventory to each Living Supports and CCS site where AT is used, for each person using AT related to that therapist's scope of service. a. The final AT inventory must be reviewed by the case manager and team for accuracy before it gets distributed to the entire IDT. **Chapter 10 Living Care Arrangements (LCA): 10.3.8 Requirements for Each Residence: Scope of Living Supports (Supported Living, Family Living, and IMLS)** The scope of all Living Supports (Supported Living, Family Living and IMLS) includes, but is not limited to the following as identified by the IDT and ISP: … 8. ensuring readily available access to and assistance with use of a person's adaptive equipment, augmentative communication, remote personal support technology (RPST) and assistive technology (AT) devices, including monitoring and support related to maintenance of such equipment and devices to ensure they are in working order; …	Based on interview the Agency did not ensure the necessary support mechanisms and devices, including the rationale for the use of assistive technology or adaptive equipment is in place for 1 of 15 Individuals. **When DSP were asked, if the Individual require any type assistive device or adaptive equipment and if they had been trained on the equipment, the following was reported:** • DSP #548 stated, "He has some. His iPad and his phone." Per the Health Passport the individual also requires glasses. (Individual #11)	**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?)*: →	

Chapter 11 Community Inclusion: 11.6.2 General Service Requirements for CCS Individual, Small Group and Group: CCS shall be selected and provided based on the interests of the person and Desired Outcomes listed in the ISP. Requirements include: 1. Conducting community-based situational assessments that include exposure to new experiences, discovery activities or other person-centered assessments. The assessment will be used to guide the IDT's planning for exposure to new community-based activities, overcoming barriers to employment and integrating clinical information, assistive technology, behavioral and therapy supports as necessary for the person to be successful in development of their meaningful day and employment.			

Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	Standard Level Deficiency		

Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023
Chapter 10 Living Care Arrangement (LCA): 10.3.7 Requirements for Each Residence (SL, FL, IMLS): 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, telephone, and internet access.
2. promotes a safe environment free of any abuse, neglect, and exploitation.
3. supports telehealth, and/ or family/friend contact on various platforms or using various devices.
4. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher.
5. has a general-purpose first aid kit.
6. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift.
7. has water temperature that does not exceed a safe temperature (110° F). Anyone with a history of being unsafe in or around water while bathing, grooming, etc. or with a history of at least one scalding incident will have a regulated temperature control valve or device installed in the home.
8. 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.
9. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy.
	Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 8 of 10 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 exceeds safe temperature (110^0 F):
	  • Water temperature in home measured 116^0 F (#3)
	  • Water temperature in home measured 111.5^0 F (#5)
	  • Water temperature in home measured 129.2^0 F (#11)
	
	Family Living Requirements:
	• Water temperature in home measured 113.4^0 F (#2)
	• Water temperature in home measured 116.5^0 F (#7, 8)
	• Water temperature in home measured 125.4^0 F (#9)
	• Water temperature in home measured 147.7^0 F (#13)
	• Water temperature in home measured 115^0 F (#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?)*: →	

10. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. 11. supports environmental modifications, remote personal support technology (RPST), and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT. 12. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed. 13. has the phone number for poison control within the line of the telephone. 14. has general household appliances, and kitchen and dining utensils. 15. has proper food storage and cleaning supplies. 16. has adequate food for three meals a day and individual preferences. 17. has at least two bathrooms for residences with more than two residents. 18. training in and assistance with community integration that include access to and participation in preferred activities to include providing or arranging for transportation needs or training to access public transportation; and 19. has Personal Protective Equipment available, when needed. **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. 3. 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.	*Note: The following Individuals share a residence:* • #1, 4 • #6, 12 • #7, 8		

20.3 Record Access for Direct Support Professional (DSP) during Service Delivery: DSP must have access to records, plans, and forms needed to adequately provide and document the type of service and specific scope of service being provided at the time.			

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**		
NMAC 8.302.2 Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 21: Billing Requirements; 23.1 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 3. Details of the services provided. 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… **21.7 Billable Activities**: Specific billable activities are defined in the scope of work and service requirements for each DD Waiver service. In addition, any	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports services for 1 of 14 individuals. Individual #9: January 2024 • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/2/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/3/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/4/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/5/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/8/2024. Documentation received accounted for 0 units as 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?)***:** →	

billable activity must also be consistent with the person's approved ISP. **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. **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. Face-to-face billable services shall be provided during the month when any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. **21.9.4 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 (H2021 HB U1) on 1/9/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/10/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/11/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/16/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/17/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/18/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/19/2024. Documentation received accounted for 0 units as services were provided concurrently with another service.		

	• The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/22/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/23/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/24/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/25/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/26/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/29/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/30/2024. Documentation received accounted for 0 units as services were provided concurrently with another service.		

	• The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 1/31/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. February 2024: • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/1/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/2/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/5/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 12 units of Customized Community Supports (H2021 HB U1) on 2/6/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/7/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/8/2024. Documentation received accounted for 0 units as services were provided concurrently with another service.		

	• The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/9/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/12/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/13/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/14/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/15/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/16/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/19/2024. Documentation received accounted for 0 units as services were provided concurrently with another service.		

	• The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/20/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/21/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/22/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/23/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/26/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/27/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/28/2024. Documentation received accounted for 0 units as services were provided concurrently with another service.		

	• The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 2/29/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. March 2024 • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/1/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/4/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/5/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/6/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/7/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/8/2024. Documentation received accounted for 0 units as services were provided concurrently with another service.		

	• The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/11/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/12/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/13/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/14/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/15/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/18/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/19/2024. Documentation received accounted for 0 units as services were provided concurrently with another service.		

	• The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/20/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/21/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/22/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/25/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/26/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/27/2024. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/28/2024. Documentation received accounted for 0 units as services were provided concurrently with another service.		

	• The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 3/29/2024. Documentation received accounted for 0 units as services were provided concurrently with another service.		

Tag # LS26 Supported Living Reimbursement	Standard Level Deficiency		
NMAC 8.302.2 Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 21: Billing Requirements; 23.1 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 3. Details of the services provided. 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… **21.7 Billable Activities**: Specific billable activities are defined in the scope of work and service requirements for each DD Waiver service. In addition, any billable activity must also be consistent with the person's approved ISP.	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 4 of 7 individuals. Individual #1 February 2024 • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 2/18/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards, at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 11 hours, which is less than the required amount. March 2024 • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 3/30/2024. No documentation was found for 3/30/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 3/31/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards, at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 7 hours, which is less than the required amount. Individual #3 January 2024 • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 1/1/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards, at least 12 hours in a 24-hour period must be provided in order to bill a	**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?)*: →	

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. **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. Face-to-face billable services shall be provided during the month when any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. **21.9.4 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.	complete unit. Documentation received accounted for 8.5 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 1/8/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards, at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount. February 2024 • The Agency billed 1 unit of Supported Living (T2016 HB – U7) on 2/4/2024. No documentation was found for 2/4/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 2/15/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards, at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 9.25 hours, which is less than the required amount. Individual #5 January 2024 • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 1/2/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards, at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8.75 hours, which is less than the required amount. March 2024		

	• The Agency billed 1 unit of Supported Living (T2016 HB U7) on 3/1/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards, at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 10.5 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 3/42024. Documentation received accounted for .5 units. As indicated by the DDW Standards, at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 3/6/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards, at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 10.5 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 3/29/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards, at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount. Individual #6 March 2024		

	• The Agency billed 1 unit of Supported Living (T2016 HB U8) on 3/13/2024. No documentation was found for 3/13/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Supported Living (T2016 HB U8) on 3/14/2024. No documentation was found for 3/14/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Supported Living (T2016 HB U8) on 3/15/2024. No documentation was found for 3/15/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Supported Living (T2016 HB U8) on 3/23/2024. No documentation was found for 3/23/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Supported Living (T2016 HB U8) on 3/24/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards, at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U8) on 3/31/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards, at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 7 hours, which is less than the required amount.		

Tag # LS27 Family Living Reimbursement	Standard Level Deficiency		
NMAC 8.302.2 Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 21: Billing Requirements; 23.1 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 3. Details of the services provided. 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… **21.7 Billable Activities**: Specific billable activities are defined in the scope of work and service requirements for each DD Waiver service. In addition, any billable activity must also be consistent with the person's approved ISP. **21.9 Billable Units**: The unit of billing depends on the service type. The unit may be a 15-	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Family Living Services for 2 of 6 individuals. Individual #7 March 2024 • The Agency billed 7 units of Family Living (T2033 HB) from 3/16 – 22, 2024. Documentation received accounted for 6 units. *(Note: No documentation was found for 3/18/2024.)* Individual #8 March 2024 • The Agency billed 7 units of Family Living (T2033 HB) from 3/16 – 22, 2024. Documentation received accounted for 6 units. *(Note: No documentation was found for 3/18/2024.)*	**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?)*: →	

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. **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. Face-to-face billable services shall be provided during the month when any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. **21.9.4 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.			

HEALTH CARE AUTHORITY

Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
Alex Castillo Smith, Deputy Secretary
Kathy Slater Huff, Deputy Secretary
Kyra Ochoa, Deputy Secretary

Date:	July 12, 2024
To:	Jamie Ortega, Owner / Director
Provider:	Hearts of Hope, LLC
Address:	1065 South Main Street, Bldg. D – Suite H
State/Zip:	Las Cruces, New Mexico 88005
E-mail Address:	jamie@heartsofhopellc.net
CC:	Scott Barela
E-Mail Address:	scott@heartsofhopellc.net
Region:	Southwest
Survey Date:	April 22 – May 3, 2024
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Supported Living, Family Living, Customized In-Home Supports, and Customized Community Supports
Survey Type:	Routine

Dear Mr. Ortega:

The Division of Health Improvement Quality Management Bureau received and reviewed the documents you submitted for your Plan of Correction. Your Plan of Correction is not closed.

Your Plan of Correction will be considered for closure when a Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections.

The Quality Management Bureau will need to conduct a verification survey to ensure previously cited deficiencies have been corrected and that systemic Quality Improvement and Quality Assurance processes have been effective at sustaining corrections.

If the Verification survey determines survey deficiencies have been corrected and corrective measures have effectively maintained compliance with DDW Standards, your Plan of Correction will be considered for closure.

If the Verification survey identifies repeat deficiencies, the Plan of Correction process will continue and your case may be referred to the Internal Review Committee for discussion of possible civil monetary penalties possible monetary fines and/or other sanctions.

Thank you for your cooperation with the Plan of Correction process.

Sincerely,

Monica Valdez, BS

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