(Upheld by IRF 11.2025)

Date:	November 3, 2025
To:	Marcus Lathon, Executive Director
Provider:	Open Arms LLC dba Open Arms Supported Living
Address:	4113 Eubank Blvd. NE, Suite 200
State/Zip:	Albuquerque, New Mexico 87111
E-mail Address:	marcus@openarmsnm.com
CC:	Ruby Lathon, Quality Assurance Specialist
E-Mail Address:	ruby@openarmsnm.com

Board Chair E-Mail Address: raphael@infitecarenm.com

Region:	Metro
Routine Survey:	May 19 - 30, 2025
Verification Survey:	October 6 - 16, 2025
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Supported Living and Customized Community Supports
Survey Type:	Verification
Team Leader:	Nicole Devoti, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Sally Karingada, BS, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Lathon;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on May 19 – 30, 2025.*

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

Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags: This determination is based on noncompliance with one to five (1 – 5) 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 # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components ***(New / Repeat Finding)***
- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements) ***(New / Repeat Finding)***
- Tag # 1A22 Agency Personnel Competency ***(Repeat Finding)***
- Tag # 1A26.1 Employee Abuse Registry ***(New Finding)***
- Tag # 1A09 Medication Delivery Routine Medication Administration ***(New / Repeat Finding)*** ***(Upheld by IRF)***

The following tags are identified as Standard Level:

- Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation) ***(New / Repeat Finding)***
- Tag # 1A26 Employee Abuse Registry ***(New / Repeat Finding)***

However, due to the new/repeat deficiencies your agency will be required to contact your DDSD Regional Office for technical assistance and follow up and complete the Plan of Correction document attached at the end of this report. Please respond to the Plan of Correction Coordinator within 10 business days of receipt of this letter.

The attached Report of Findings identifies the new/repeat Condition of Participation Level deficiencies found during your agency's verification compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 10 business days from the receipt of this letter to submit the Plan of Correction (POC). The POC must include the following:

1. Evidence your agency has contacted your DDSD Regional Office for technical assistance.
2. A Plan of Correction detailing Corrective Action for any new/repeat deficiencies and Quality Assurance/Quality Improvement processes to prevent your agency from receiving deficiencies in the future.
3. Upon notification that your POC has been approved, you will have 3 days to submit documents verifying that all deficiencies have been corrected and evidence of the ongoing Quality Assurance/Quality Improvement (QA/QI) processes.

Submission of your Plan of Correction:
Please submit your agency's Plan of using the format at the end of this report within 10 business days of receipt of this letter to the parties below:

1. **Quality Management Bureau, Kayla Benally, Healthcare Surveyor Advanced / Plan of Correction Coordinator** at kayla.benally@hca.nm.gov

2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

Please submit documents electronically within 3 business days of the POC being approved according to the following: If the documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to the POC Coordinator at kayla.benally@hca.nm.gov. 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.

Failure to submit your POC and documents within the allotted timeframes may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Please contact the Plan of Correction Coordinator, Kayla Benally at 505-670-6290 or email at: kayla.benally@hca.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,

Nicole Devoti, BA

Nicole Devoti, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	October 6, 2025
Contact:	**Open Arms LLC dba Open Arms Supported Living** Ruby Lathon, Quality Assurance Specialist **HCA/DHI/QMB** Nicole Devoti, BA, Team Lead/Healthcare Surveyor
Entrance Conference Date:	October 6, 2025
Present:	**Open Arms LLC dba Open Arms Supported Living** Marcus Lathon, Executive Director Ruby Lathon, Quality Assurance Specialist **HCA/DHI/QMB** Nicole Devoti, BA, Team Lead/Healthcare Surveyor Sally Karingada, BS, Healthcare Surveyor Supervisor
Exit Conference Date:	October 16, 2025
Present:	**Open Arms LLC dba Open Arms Supported Living** Marcus Lathon, Executive Director Ruby Lathon, Quality Assurance Specialist **HCA/DHI/QMB** Nicole Devoti, BA, Team Lead/Healthcare Surveyor Sally Karingada, BS, Healthcare Surveyor Supervisor
Total Compliance Survey Sample Size:	4 3 - Supported Living 4 - Customized Community Supports
Persons Served Records Reviewed	4
Direct Support Professional Records Reviewed	20
Direct Support Professional Interviewed during Routine Survey	3
Service Coordinator Records Reviewed	1
Administrative Interview completed during Routine Survey	1
Nurse Interview completed during Routine Survey	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
    - 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: HCA - Division of Health Improvement
HCA - Developmental Disabilities Supports Division
HCA - Medical Assistance Division

Attachment B

Division of Health Improvement / Quality Management Bureau
QMB Determination of Compliance Process

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and other state and federal regulations. For the purpose of the LCA / CI survey the CMS waiver assurances have been grouped into four (4) Service Domains: Plan of Care (ISP Implementation); Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Assurance system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

Each deficiency in your Report of Findings has been predetermined to be a Standard Level Deficiency, a Condition of Participation Level Deficiency, if below 85% compliance or a non-negotiable Condition of Participation Level Deficiency. Your Agency's overall Compliance Determination is based on a Scope and Severity Scale which takes into account the number of Standard and Condition Level Tags cited as well as the percentage of Individuals affected in the sample.

Conditions of Participation (CoPs)

CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances, in addition to the New Mexico Developmental Disability Waiver (DDW) Service Standards. The Division of Health Improvement (DHI), in conjunction with the Developmental Disability Support Division (DDSD), has identified certain deficiencies that have the potential to be a Condition of Participation Level, if the tag falls below 85% compliance based on the number of people affected. Additionally, there are what are called non-negotiable Conditions of Participation, regardless if one person or multiple people are affected. In this context, a CoP is defined as an essential / fundamental regulation or standard, which when out of compliance directly affects the health and welfare of the Individuals served. If no deficiencies within a Tag are at the level of a CoP, it is cited as a Standard Level Deficiency.

Service Domains and CoPs for Living Care Arrangements and Community Inclusion are as follows:

Service Domain: Service Plan: ISP Implementation - *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A08.3 –** Administrative Case File: Individual Service Plan / ISP Components
- **1A32 –** Administrative Case File: Individual Service Plan Implementation
- **LS14 –** Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- **IS14 –** CCS / CIES Service Delivery Site Case File (ISP and Healthcare Requirements)

Service Domain: Qualified Providers - *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A20 -** Direct Support Personnel Training

- **1A22 -** Agency Personnel Competency
- **1A37 –** Individual Specific Training

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):
- **1A25.1 –** Caregiver Criminal History Screening
- **1A26.1 –** Consolidated On-line Registry Employee Abuse Registry

Service Domain: Health, Welfare and Safety - *The State, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*

Potential Condition of Participation Level Tags, if compliance is below 85%:
- **1A08.2 –** Administrative Case File: Healthcare Requirements & Follow-up
- **1A09 –** Medication Delivery Routine Medication Administration
- **1A09.1 –** Medication Delivery PRN Medication Administration
- **1A09.2 –** Medication Delivery Nurse Approval for PRN Medication
- **1A15.2 –** Administrative Case File: Healthcare Documentation (Therap and Required Plans)

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):
- **1A05 –** General Requirements / Agency Policy and Procedure Requirements
- **1A07 –** Social Security Income (SSI) Payments
- **1A15 –** Healthcare Documentation - Nurse Availability
- **1A31 –** Client Rights/Human Rights
- **LS25.1 –** Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

Attachment C

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

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

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB 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 The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
3. 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@hca.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 standard level tags, as well as, 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 two ways an agency can receive a determination of Non-Compliance:

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

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

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

Agency: **Open Arms LLC dba Open Arms Supported Living – Metro Region**
Program: Developmental Disabilities Waiver
Service: Supported Living and Customized Community Supports
Survey Type: Verification
Routine Survey: **May 19 - 30, 2025**
Verification Survey: **October 6- 16, 2025**

Standard of Care	Routine Survey Deficiencies May 19 - 30, 2025	Verification Survey New and Repeat Deficiencies October 6- 16, 2025
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 # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	**Condition of Participation Level Deficiency**	**Condition of Participation Level Deficiency**
NMAC 8.371.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY. **NMAC 8.371.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS.** Developmental Disabilities Waiver Service Standards Original Issue:11/1/2021 Reissue eff.: 7.1.2024 **Chapter 6: Individual Service Plan (ISP)** The CMS requires a person-centered service plan for every person receiving HCBS. The DD Waiver's person-centered service plan is the ISP.	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 at the administrative office for 2 of 4 individuals. Review of the Agency administrative 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 #1:*** *TSS not found for the following,* Work / Education / Volunteer *Outcome Statement / Action Steps:* • "...will make a schedule." ***Individual #3:*** *TSS not found for the following, Live Outcome Statement / Action Steps:* • "With staff assistance … will write a list of needed ingredients." • "With staff assistance … will go shopping for needed items."	**New / Repeat Findings:** 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 at the administrative office for 2 of 4 individuals. Review of the Agency administrative 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 #1:*** *TSS not found for the following,* Work / Education / Volunteer *Outcome Statement / Action Steps:* • "...will make a schedule." ***Individual #3:*** *TSS not found for the following, Fun Outcome Statement / Action Steps:* • "… will invite a peer(s) to go on an outing with her staff."

6.6 DDSD ISP Template: The ISP must be written according to templates provided by the DDSD. Both children and adults have designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e., an acknowledgement of receipt of specific information) and other elements depending on the age and status of the individual. The ISP templates may be revised and reissued by DDSD to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDSD and be required for use to better demonstrate required elements of the PCP process and ISP development. **6.6.1 Vision Statements: The long-term vision statement describes the person's major long-term (e.g., within one to three years) life dreams and aspirations in the following areas:** 1. Live, 2. Work/Education/Volunteer, 3. Develop Relationships/Have Fun, and 4. Health and/or Other (Optional) **6.6.2 Desired Outcomes:** A Desired Outcome is required for each life area (Live, Work, Fun) for which the person receives paid supports through the DD Waiver. Each service does not need its own, separate outcome, but should be connected to at least one Desired Outcome. **6.6.3.1 Action Plan:** Each Desired Outcome requires an Action Plan. The Action Plan addresses individual strengths and capabilities in reaching Desired Outcomes. Multiple service types may be included in the Action Plan under a single Desired Outcome. **6.6.3.2 Teaching and Supports Strategies (TSS) and Written Direct Support Instructions (WDSI):** After the ISP meeting, IDT members conduct a task analysis and assessments necessary to create		

effective TSS and WDSI to support those Action Plans that require this extra detail. **6.6.3.3 Individual Specific Training in the ISP:** The CM, with input from each DD Waiver Provider Agency at the annual ISP meeting, completes the IST requirements section of the ISP form listing all training needs specific to the individual. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.		

Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)	Condition of Participation Level Deficiency	Condition of Participation Level Deficiency
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **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 are 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	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 4 of 4 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 #1:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "…will make a grocery list of needed items." • "…will prepare the recipe." *TSS not found for the following Work / Learn Outcome Statement / Action Steps:* • "…will make a schedule." ***Individual #2:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "I will select my chore." ***Individual #3:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "With staff assistance … will look up recipes." • "With staff assistance … will write a list of needed ingredients."	**New / Repeat Findings:** 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 2 of 3 Individuals receiving Living Care Arrangements. Per the agency's Plan of Correction "Open Arms Supported Living will review and complete the missing documentation in the ISP Teaching and Support Strategies for Individuals #1, #2, #3, and #4, accordingly. • Open Arms Supported Living will review and provide missing documentation in the Healthcare Passports for Individuals #1, #2, #3, and #4. • Open Arms Supported Living will review and complete the missing documentation in the Comprehensive Aspiration Risk Management Plan for Individuals #2 and #4 • Open Arms Supported Living will review and update any missing documentation in the Healthcare Plan for Individuals #1 and #4 to ensure the identified items are addressed and corrected. Open Arms will review its QA Plan and audit schedule which includes monthly audits and training. Action Steps: • OASL will conduct an internal audit of client files, medication records, and service delivery site files including Individual Service Plans (ISPs), Teaching Support Strategies (TSS), Health Care Plans (HCPs), Positive Behavior Support Plans (PBSP), Behavior Crisis Intervention Plans (BCIP), and other relevant documents. • Ensure all required documents are present, complete, and accurate before distribution, during use, and after completion…"

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	• "With staff assistance … will go shopping for needed items." • "With staff assistance … will make her chosen recipe." ***Individual #4:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "…will verbally express choice (yes or no)." *TSS not found for the following Fun / Relationship Outcome Statement / Action Steps:* • "…will participate in a new activity in the community." **Healthcare Passport:** • Not Found (#1, 3) • Not Current (#2, 4) **Comprehensive Aspiration Risk Management Plan:** • Not Found (#2) • Not Current (#4) **Health Care Plans:** • Constipation (#4) • Endocrine (#1) • Own Blood Glucose Monitoring (#1) • Risk of Dehydration (#4) • Risk for Falls (#1) • Seizures (#1) • Self-Administration of Insulin (#1) • Self-Care Deficit: Hygiene, Bathing, Dressing, Grooming and Toileting (#1)	No evidence was provided to ensure corrective action was taken for Individuals #2 and 4, as it relates to the following: **ISP Teaching and Support Strategies:** ***Individual #2:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "I will select the dessert I will bake." • "I will gather the ingredients I will need." ***Individual #4:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "…will verbally express choice (yes or no)." **Comprehensive Aspiration Risk Management Plan:** • Not Found (#2) **Health Care Plans:** • Risk of Dehydration (#4) **Healthcare Passport:** • Not Found (#2)

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.		

Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)	Standard Level Deficiency	Standard Level Deficiency
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **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 are 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	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 2 of 4 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: **Positive Behavioral Supports Plan:** • Not Current (#2, 4)	**New / Repeat Finding:** Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 1 of 3 Individuals receiving Living Care Arrangements. Per the agency's Plan of Correction "Open Arms Supported Living (OASL) will review and complete the Positive Behavioral Support Plan (PBSP) for Individuals #2 and #4. Responsible personnel will be retrained. Action Steps: • OASL will conduct an internal audit of client files, medication records, and service delivery site files including Individual Service Plans (ISPs), Teaching Support Strategies (TSS), Health Care Plans (HCPs), Positive Behavior Support Plans (PBSP), Behavior Crisis Intervention Plans (BCIP), and other relevant documents. • Ensure all required documents are present, complete, and accurate before distribution, during use, and after completion…" No evidence was provided to ensure corrective action was taken for Individual #4, as it relates to the following: **Positive Behavioral Supports Plan:** • Not Found (#4)

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.		

Standard of Care	Routine Survey Deficiencies May 19 - 30, 2025	Verification Survey New and Repeat Deficiencies October 6- 16, 2025
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**	**Condition of Participation Level Deficiency**
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **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 techniques are maintained and to provide additional coaching/feedback. Individuals shall receive	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 3 of 7 Direct Support Professional. **When DSP were asked, what State Agency do you report suspected Abuse, Neglect or Exploitation to, the following was reported:** • DSP #517 stated, "I'll call the agency." Staff was not able to identify the State Agency as Division of Health Improvement or Adult Protective Services. **When DSP were asked to give examples of Abuse, Neglect and Exploitation, the following was reported:** • DSP #506 stated, "I don't know" was DSP's response with regards to exploitation. **When DSP were asked, if the Individual had Positive Behavioral Supports Plan (PBSP), If have they had been trained on the PBSP and what does the plan cover, the following was reported:** • DSP #506 stated, "Not that I would know." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan and DSP are required to be trained. (Individual #2)	**Repeat Finding:** 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 training competencies were met for 1 of 3 Direct Support Professional. Per the Agency's Plan of Correction, the agency stated, "Open Arms Supported Living will schedule trainings and complete trainings for all Direct Support Professionals, Direct Support Supervisory Personnel and Service Coordinators, including DSPs #505, 506, and 517, and will include the following trainings: o Abuse, Neglect and Exploitation o Positive Behavior Support Plans (PBSP) o Health Care Plans (HCPs) o eCHAT o Individual Service Plans (ISPs), Teaching Support Strategies (TSS), Behavior Crisis Intervention Plans (BCIP), and other relevant documents." No evidence was provided to indicate DSP # 505 was trained on Healthcare Plans for Dehydration and Constipation for Individual #4, as previously cited.

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…	**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 #505 stated, "I am not aware of any." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Dehydration & Constipation. (Individual #4) • DSP #517 stated, "No, not that I am aware." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Increased BMI, Self-Care Deficit: bathing/hygiene/dressing/grooming/toileting, and History of Falls. (Individual #3) **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 #505 stated, "No food allergies, but he has one for Haldol." As indicated by the Electronic Comprehensive Health Assessment Tool, the individual is allergic to grapefruit. (Individual #4)	

Tag # 1A26 Employee Abuse Registry	Standard Level Deficiency	Standard Level Deficiency
NMAC 8.370.8 - EMPLOYEE ABUSE REGISTRY: This rule applies to a broad range of New Mexico providers of health care and services and employees of these providers who are not licensed health care professionals or certified nurse aides. This rule requires that providers check with the registry and avoid employing an individual on the registry. This rule provides for the investigation and determination of complaints alleging abuse, neglect or exploitation of recipients of care or services by employees. This rule further requires listing employees with substantiated registry-referred abuse, neglect or exploitation on the registry, following an opportunity for a hearing. This rule supplements other pre-employment screening requirements currently applicable to health care providers, such as the requirement for criminal history screening of caregivers employed by care providers subject to the Caregiver Criminal History Screening Act, Sections 29-17-1 et seq. NMSA 1978, and that Act's implementing rule, 8.370.5 NMAC. It also supplements requirements for pre-employment screening of certified nurse aides applicable to nursing facilities pursuant to 42 CFR Sections 483.75(e) and 488.335; and 8.370.25 NMAC. This rule does not address the consequences of abuse, neglect, or exploitation for which a provider, as distinguished from an employee, is responsible. **8.370.8.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:** Upon the effective date of this rule, the authority 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 authority, as a result of an investigation of a complaint, to have engaged in a	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 8 of 20 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Professional (DSP):** • #501 – Date of hire 4/15/2025, completed 4/17/2025. • #502 – Date of hire 12/6/2024, completed 12/08/2024. • #504 – Date of hire 1/17/2025, completed 2/12/2025. • #506 – Date of hire 1/10/2025, completed 1/14/2025. • #512 – Date of hire 1/17/2025, completed 2/12/2025. • #514 – Date of hire 1/28/2025, completed 1/30/2025. • #516 – Date of hire 5/1/2025, completed 5/21/2025. • #518 – Date of hire 9/9/2024, completed 9/12/2024.	**New / Repeat Findings:** Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 2 of 21 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Professional (DSP):** • #525 – Date of hire 8/6/2025, completed 8/12/2025. • #526 – Date of hire 9/14/2025, completed 9/28/2025.

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 business days following receipt. Only authority 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. **D. Documentation of inquiry to registry.** The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. **E. Documentation for other staff.** With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.		

Tag # 1A26.1 Employee Abuse Registry		Condition of Participation Level Deficiency
NMAC 8.370.8 - EMPLOYEE ABUSE REGISTRY: This rule applies to a broad range of New Mexico providers of health care and services and employees of these providers who are not licensed health care professionals or certified nurse aides. This rule requires that providers check with the registry and avoid employing an individual on the registry. This rule provides for the investigation and determination of complaints alleging abuse, neglect or exploitation of recipients of care or services by employees. This rule further requires listing employees with substantiated registry-referred abuse, neglect or exploitation on the registry, following an opportunity for a hearing. This rule supplements other pre-employment screening requirements currently applicable to health care providers, such as the requirement for criminal history screening of caregivers employed by care providers subject to the Caregiver Criminal History Screening Act, Sections 29-17-1 et seq. NMSA 1978, and that Act's implementing rule, 8.370.5 NMAC. It also supplements requirements for pre-employment screening of certified nurse aides applicable to nursing facilities pursuant to 42 CFR Sections 483.75(e) and 488.335; and 8.370.25 NMAC. This rule does not address the consequences of abuse, neglect, or exploitation for which a provider, as distinguished from an employee, is responsible. **8.370.8.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:** Upon the effective date of this rule, the authority 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 authority, as a result of an investigation of a complaint, to have engaged in a	**N/A**	**New Findings:** 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 in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 2 of 21 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:** **Direct Support Professional (DSP):** • #522 – Date of hire 9/29/2025. • #527 – Date of hire 6/2/2024. *(Note: DSP was not listed in the original personnel list during the routine survey).*

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 business days following receipt. Only authority 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. **D. Documentation of inquiry to registry.** The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. **E. Documentation for other staff.** With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.		

Standard of Care	Deficiencies	Verification Survey New and Repeat Deficiencies October 6- 16, 2025
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 # 1A09 Medication Delivery Routine Medication Administration ***(Upheld by IRF)***	**Condition of Participation Level Deficiency**	**Condition of Participation Level Deficiency**
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **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	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 April and May 2025. Based on record review, 1 of 4 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #4 April 2025 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Oxcarbazepine 300 MG (2 times daily) – Blank 4/25 (8:00 AM)	**New / Repeat Finding:** 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 month of September 2025. Based on record review, 1 of 3 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #2 September 2025 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Bacitracin 500 unit/GM Ointment (3 times daily) – Blank 9/18 (2:00 PM & 8:00 PM) Per the Agency's Plan of Correction, the agency stated, "Open Arms Supported Living will review and complete Medication Administration Records for Individual #4 to include required documentation and missing entries. Responsible staff will be retrained on Medication Administration Record (MAR) documentation." *(Finding Upheld by IRF)*

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

Standard of Care	Routine Survey Deficiencies May 19 - 30, 2025	Verification Survey New and Repeat Deficiencies October 6- 16, 2025
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # 1A08 Administrative Case File (Other Required Documents)	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A08.1 Administrative and Residential Case File: Progress Notes	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	**Condition of Participation Level Deficiency**	**COMPLETE**
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 # 1A20 Direct Support Professional Training	**Condition of Participation Level Deficiency**	**COMPLETE**
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	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A09.1 Medication Delivery PRN Medication Administration	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A27.0 Immediate Action and Safety Plan	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A33.1 Board of Pharmacy - License	**Standard Level Deficiency**	**COMPLETE**
Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	**Standard Level Deficiency**	**COMPLETE**
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**	**COMPLETE**
Tag # LS26 Supported Living Reimbursement	**Standard Level Deficiency**	**COMPLETE**

	Verification Survey Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	**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 # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)	**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 # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)	**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 # 1A22 Agency Personnel Competency	**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 # 1A26 Employee Abuse Registry	**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 # 1A26.1 Employee Abuse Registry	**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 # 1A09 Medication Delivery Routine Medication Administration	**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?)*: →	

HEALTH CARE
AUTHORITY

Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
Alex Castillo Smith, Deputy Secretary
Kathy Slater Huff, Deputy Secretary
Niki Kozlowski, Acting Deputy Secretary
Dana Flannery, Medicaid Director

Date: November 25, 2025

To: Marcus Lathon, Executive Director

Provider: Open Arms LLC dba Open Arms Supported Living
Address: 4113 Eubank Blvd. NE, Suite 200
State/Zip: Albuquerque, New Mexico 87111

E-mail Address: marcus@openarmsnm.com

CC: Ruby Lathon, Quality Assurance Specialist
E-Mail Address: ruby@openarmsnm.com

Board Chair E-Mail Address: raphael@infinitecarenm.com

Region: Metro
Routine Survey: May 19 - 30, 2025
Verification Survey: October 6 - 16, 2025

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Supported Living and Customized Community Supports

Survey Type: Verification

Dear Mr. Lathon:

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

The Plan of Correction process is now complete.

Furthermore, your agency is now determined to be in Compliance with all Conditions of Participation.

To maintain ongoing compliance with standards and regulations, continue to use the Quality Assurance (self-auditing) processes you described in your Plan of Correction.

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

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

Sincerely,

Kayla R. Benally, BSW

Kayla R. Benally, BSW
Healthcare Surveyor Advanced/Plan of Correction Coordinator
DHI - Quality Management Bureau