Date:	January 14, 2019
To:	Jennie Osness, Quality Assurance Manager
Provider:	Harmony Home Health, Limited Liability Company
Address:	5700 S. Harper Dr. NE, Suite 280
State/Zip:	Albuquerque, New Mexico 88109
E-mail Address:	jennieo@harmonyhomehealth.com
CC:	Anitha Thomisee, RN, Pediatric Case Manager - Supervisor
Address:	5700 S. Harper Dr. NE, Suite 280
State/Zip:	Albuquerque, New Mexico 88109
E-Mail Address:	anithat@harmonyhomehealth.com
Region:	Metro
Survey Date:	November 2 – 8, 2018
Program Surveyed:	Medically Fragile Waiver
Service Surveyed:	Respite Home Health Aide and Respite Private Duty Nursing
Survey Type:	Routine
Team Leader:	Crystal Lopez-Beck, BA, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau
Team Members:	Yolanda J. Herrera, RN, Healthcare Nurse Surveyor, Division of Health Improvement/Quality Management Bureau, Iris Clevenger, RN, BSN, MA, CCM, Medically Fragile Waiver (MFW) Program Manager, Developmental Disability Supports Division

Dear Ms. J. Osness:

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

Plan of Correction:

The attached Report of Findings identifies the deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction (POC). 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.

During the exit interview of your on-site survey Attachment A on the Plan of Correction Process was provided to you. Please refer to 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:

- 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? (i.e., file reviews, periodic check with checklist, 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)
- What steps will be taken if issues are found? (i.e., retraining, requesting documents, filing RORA, etc.)

Submission of your Plan of Correction:

Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. *(See attachment "A" for additional guidance in completing the Plan of Correction)*.

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

1. **Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator 1170 North Solano Suite D Las Cruces, New Mexico 88001**

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 claims or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: *Lisa Medina-Lujan*
HSD/OIG/Program Integrity Unit
1474 Rodeo Road
Santa Fe, New Mexico 87505

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

Lisa Medina-Lujan (Lisa.medina-lujan@state.nm.us)
OR
Jennifer Goble (Jennifer.goble2@state.nm.us)

Please be advised that there is a one-week lag period for applying payments received by check to Voided/Adjusted 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:

QMB Deputy Bureau Chief
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator, Amanda Castaneda, at (575) 373-5716 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,

Crystal Lopez-Beck, BA

Crystal Lopez-Beck, BA
Deputy Bureau Chief / Team Lead
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	November 2, 2018	
Contact:	**Harmony Home Health, Limited Liability Company** Jennie Osness, Quality Assurance Manager Anitha Thomisee, RN, Pediatric Case Manager - Supervisor **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Deputy Bureau Chief / Team Lead Yolanda J. Herrera, RN, Nurse Healthcare Surveyor	
On-site Entrance Conference Date:	November 5, 2018	
Present:	**Harmony Home Health, Limited Liability Company** Anitha Thomisee, RN, Pediatric Case Manager - Supervisor **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Deputy Bureau Chief / Team Lead Yolanda J. Herrera, RN, Nurse Healthcare Surveyor **DDSD/Clinical Services Bureau** Iris Clevenger, RN, BSN, MA, CCM, MFW Program Manager	
Exit Conference Date:	November 8, 2018	
Present:	**Harmony Home Health, Limited Liability Company** Jennie Osness, Quality Assurance Manager (via phone) Anitha Thomisee, RN, Pediatric Case Manager - Supervisor Angela Abeyta, RN, Clinical Nurse Supervisor Laurel Powell, Operations Director (via phone) Heather Mills, Clinical Lead (via phone) **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Deputy Bureau Chief / Team Lead Yolanda J. Herrera, RN, Nurse Healthcare Surveyor **DDSD/Clinical Services Bureau** Iris Clevenger, RN, BSN, MA, CCM, MFW Program Manager	
Administrative Locations Visited Number:	Number	1
Total Sample Size	Number:	6 2 – Respite Home Health Aide (HHA) 4 – Respite Private Duty Nursing (PDN)
Total Homes Visited	Number:	5 (Two Individuals live in the same residence.)
Persons Served Records Reviewed	Number:	6

Recipient/Family Members Interviewed	Number:	5 (Two Individuals on the sample were siblings and the same family member was interviewed for both.)
Home Health Aide Records Reviewed	Number:	4
Home Health Aide Interviewed	Number:	2
Private Duty Nursing Records Reviewed	Number:	11
Private Duty Nursing Interviewed	Number:	3
Administrative Personnel Interviewed	Number:	2

Administrative Files Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Internal Incident Management Reports and System Process/ General Events Reports
- Agency Policy and Procedure to include, but not limited to:
    - Transportation Policy and Procedure
    - Tuberculosis Policy and Procedure
    - Rights and Responsibilities and Grievance Policy and Procedures
    - Cultural Sensitivity Policy and Procedure
- Case Files
- Quality Assurance / Improvement Plan
- Personnel Files – including nursing and subcontracted staff
- Staff Training Records, including staff training hours, competency and interviews with staff
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Cardiopulmonary Resuscitation (CPR) for Home Health Aides
- Licensure/Certification for Nursing

CC Distribution List:
DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
MFEAD – NM Attorney General

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 Internal Review Committee [IRC] for possible actions or sanctions).

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings (Providers who fail to complete a POC within the 45 business days allowed will be referred to the IRC for possible actions or sanctions.)

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment "C").

Instructions for Completing Agency POC:

Required Content
Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, 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 Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

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 individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and sustained. This QA plan

must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and

5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
6. The POC must be signed and dated by the agency director or other authorized official.

The following details should be considered when developing your Plan of Correction:

- Details about how and when Consumer, Personnel and Residential 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, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc.;
- How accuracy in Billing/Reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how Individual Specific Plans are reviewed to verify they meet requirements, how the timeliness of 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 should 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, Amanda E Castaneda at (575) 373-5716 email at AmandaE.Castaneda@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda E. Castaneda, POC Coordinator in any of the following ways:
    a. Electronically at AmandaE.Castaneda@state.nm.us *(preferred method)*
    b. Fax to (575) 528-5019, or
    c. Mail to POC Coordinator, 1170 N. Solano Suite D, Las Cruces, NM 88001
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approved” or “denied.”

a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45-business day limit is in effect.
c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
e. Please note that all POC correspondence will be sent electronically unless otherwise requested.

7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a ***maximum*** of 45 business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (scanned and attached to e-mails).
3. All submitted documents ***must be annotated***; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:
    a. Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
    b. Copies of "void and adjust" forms submitted to Xerox State Healthcare, LLC to correct all unjustified units identified and submitted for payment during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

Attachment C

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

Introduction:

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

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: https://nmhealth.org/about/dhi/cbp/irf/
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRF process, email the IRF Chairperson, Crystal Lopez-Beck at crystal.lopez-beck@state.nm.us for assistance.

The following limitations apply to the IRF process:

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

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

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

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

Agency: **Harmony Home Health, Limited Liability Company – Metro Region**
Program: Medically Fragile Waiver
Service: Respite Home Health Aide (HHA) and Respite Private Duty Nursing (PDN)
Survey Type: Routine
Survey Dates: **November 2 – 8, 2018**

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Agency Record Requirements:			
TAG # MF05 Documentation Requirements – Agency Case Files			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 **GENERAL PROVIDER REQUIREMENTS** **I. <u>PROVIDER REQUIREMENTS:</u>** L. Provider Agency Case File for the Waiver Participant: 1. All provider agencies shall maintain at the administrative office a confidential case file for each individual that includes all the following elements: a. Emergency contact information for the following individuals/entities that includes addresses and telephone numbers for each: 1. Consumer 2. Primary caregiver 3. Family/relatives, guardians or conservators 4. Significant friends 5. Physician 6. Case manager 7. Provider agencies	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 5 of 6 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Emergency Contact Information:** ° Did not contain Individuals address and telephone number Information (#7) ° Did not contain Family/Relatives, Guardians or Conservators Information (#5, 7) ° Did not contain Physician's Information (#7) ° Did not contain Pharmacy Information (#2, 3, 5, 6, 7) ° Did not contain Case Manager Information (#3, 5, 6, 7) ° Did not contain Provider Agencies	**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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

8. Pharmacy b. Individual's health plan, if appropriate c. Individual's current ISP d. Progress notes and other service delivery documentation e. A medical history that shall include at least: demographic data; current and past medical diagnoses including the cause of the medically fragile conditions and developmental disability; medical and psychiatric diagnoses; allergies (food, environmental, medications); immunizations; and mostrecent physical exam. f. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. M. Documentation: 1. Provider agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to the individuals who are currently receiving services. The provider agency records shall be sufficiently detained to substantiate the date, time, individual name, servicing provider agency, level of services and length of service billed. 2. The documentation of the billable time spent with an individual shall be kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record shall contain at least the following information: a. Date and start and end time of each	Information (#2, 3, 5, 6, 7)		

serviced encounter or other billable service interval. b. A description of what occurred during the encounter or service interval. c. Signature and title of staff providing the service verifying that the service and time are correct. 3. All records pertaining to services provided to an individual shall be maintained for a least six (6) years from the date of creation. 4. Verified electronic signatures may be used. An electronic signature must be HIPAA compliant, which means the attribute affixed to an electronic document must bind to a particular party. An electronic signature secures the user authentication (proof of claimed identity at the time the signature is generated. It also creates the logical manifestations of signature (including the possibility for multiple parties to sign a document and have the order of application recognized and proven). It supplies additional information such as time stamp and signature purpose specific to that user and ensures the integrity of the signed document to enable transportability of data, independent verifiability and continuity of signature capability. If an entity uses electronic signatures, the signature method must assure that the signature is attributable to a specific person and binding of the signature with each particular document. N. All agencies must follow all applicable DDSD Policies and Procedures. O. All provider agencies that enter in to a contractual relationship with DOH to provide			

MFW services shall comply with all applicable standards herein set forth and are subject to sanctions for noncompliance with the provider agreement and all applicable rules and regulation.			

TAG # MF22 Private Duty Nursing – Scope of Services – Plans / Assessments			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 **PRIVATE DUTY NURSING** All waiver recipients are eligible to receive in-home private duty nursing (PDN) services by a registered nurse (RN) or licensed practical nurse (LPN) per capped units/hours determined by approved Level of Care (LOC) Abstract, and when nursing is identified as a need on the Individual Service Plan (ISP). Under the direction of the participant's Physician(s) /Healthcare Practitioner and in conjunction with the Case Manager (CM), participant and the primary caregiver, the private duty nurse will develop and implement a nursing care plan that is separate from the ISP. PDN services for Medically Fragile Waiver (MFW) participants under the age of 21 are funded through the Medicaid Early Periodic Screening, Diagnostic & Treatment (EPSDT) program. This service standard is intended for the MFW participant 21 years and older. I. **SCOPE OF SERVICE** A. Initiation of PDN Services: When a PDN service is identified as a recommended service, the CM will provide the participant/participant representative with a Secondary Freedom of Choice (SFOC) form from which the participant/participant representative Selects a Home Health (HH) Agency. Working with the HH Agency and participant/participant representative, the CM will facilitate the selection of an RN or	Based on record review and interview, the Agency did not maintain complete documentation of private duty nursing scope of service for 6 of 6 individuals served. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Annual Comprehensive Assessment:** • Not Found (#2, 4, 6, 7) **CMS-485 60 Day Review/Renewal:** • Individual #3 - Certification periods not renewed by PCP every 60 days as required. CMS-485 signed by PCP on 5/29/2018; next certification period not signed until 8/29/2018. • Individual #5 - Certification periods not renewed by PCP every 60 days as required. CMS-485 signed by PCP on 7/18/2018; next certification period not signed until 10/10/2018. • Individual #6 - Certification periods not renewed by PCP every 60 days as required. CMS-485 signed by PCP on 12/27/2017; next certification period not signed until 4/12/2018. • Individual #7 - Certification periods not renewed by PCP every 60 days as required. CMS-485 signed by PCP on 10/31/2017; next certification period not signed until 1/9/2018. **Nursing Care Plans;** • Not Found (#2, 3, 4, 5, 6, 7) **When Agency Personnel was asked if they**	**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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

LPN employed by the chosen agency. The identified agency will obtain a referral/prescription from the Primary Care Provider (PCP) for PDN services. This referral/prescription will be in accordance with Federal and State regulations for licensed HH Agencies. A copy of the written referral will be maintained in the participant's file at the HH Agency. This must be obtained before initiation of treatment. The CM is responsible for including recommended units/hours of service on the MAD 046 form. It is the responsibility of the participant/participant representative, HH agency and CM to assure that units/hours of therapy do not exceed the capped dollar amount determined for the participant's LOC and ISP cycle. Strategies, support plans, goals and outcomes will be developed based on the identified strengths, concerns, priorities and outcomes in the ISP. B. Private Duty Nursing Services Include 1. The private duty nurse will provide nursing services in accordance with the New Mexico Nursing Practice Act, NMSA 1978 61-3-1, et seq. 2. The private duty nurse will develop, implement, evaluate and coordinate the participant's plan of care on a continuing basis. This plan of care may require coordination with multiple agencies. A copy of the plan of care must be maintained in the participant home. 3. The private duty nurse will provide the participant, caregiver and family all the training and education pertinent to the treatment plan and equipment used by the participant. 4. The private duty nurse will meet	**had received a copy of the ISP or the Plan of Care, the following was reported;** • LPN #212 stated, "No"		

documentation requirements of the MFW, Federal and State HH Agency licensing regulations and all policies and procedures of the HH Agency where the nurse is employed. All documentation will include dates and types of treatments performed; as well as participant's response to treatment and progress towards all goals. 5. The private duty nurse will follow the National HH Agency regulations (42 CFR 484) and state HH Agency licensing regulation (7.28.2 NMAC) that apply to PDN services. 6. The private duty nurse will implement the Physician/Healthcare Practitioner orders. 7. The standardized CMS-485 (Home Health Certification and Plan of care) form will be reviewed by the RN supervisor or RN designee and renewed by the PCP at least every sixty (60) days. 8. The private duty nurse will administer Physician/Healthcare Practitioner ordered medication as prescribed utilizing all Federal, State and MFW regulations and following HH Agency policies and procedures. This includes all ordered medication routes including oral, infusion therapy, subcutaneous, intramuscular, feeding tubes, sublingual, topical and inhalation therapy. 9. Medication profiles must be maintained for each participant with the original kept at the HH Agency and a copy in the home. The medication profile will be reviewed by the licensed HH Agency RN supervisor or RN designee at least every sixty (60) days. 10. The private duty nurse is responsible for			

checking and knowing the following regarding medications: a. Medication changes, discontinued medication and new medication, and will communicate changes to all pertinent providers, primary care giver and family b. Response to medication c. Reason for medication d. Adverse reactions e. Significant side effects f. Drug allergies g. Contraindications 11. The private duty nurse will follow the HH Agency's policy and procedure for management of medication errors. 12. The private duty nurse providing direct care to a participant will be oriented to the unique needs of the participant by the family, HH Agency and other resources as needed, prior to the nurse providing independent services for the participant. 13. The private duty nurse will develop and maintain skills to safely manage all devices and equipment needed in providing care for the participant. 14. The private duty nurse will monitor all equipment for safe functioning and will facilitate maintenance and repair as needed. 15. The private duty nurse will obtain pertinent medical history. 16. The private duty nurse will be responsible for the following: a. Obtain pertinent medical history. b. Assist in the development and implementation of bowel and bladder regimens and monitor such regiments and modify as needed.			

This includes removal of fecal impactions and bowel and/or bladder training. Also included is urinary catheter and supra-pubic catheter care. c. Assist with the development, implementation, modification and monitoring of nutritional needs via feeding tubes and orally per Physician/Healthcare Practitioner order within the nursing scope of practice. d. Provide ostomy care per Physician/Healthcare Practitioner order. e. Monitor respiratory status and treatments including the participant's response to therapy. f. Provide rehabilitative nursing. g. Be responsible for collecting specimens and obtaining cultures per Physician/Healthcare Practitioner order. h. Provide routine assessment, implementation, modification and monitoring of skin conditions and wounds. i. Provide routine assessment, implementation, modification and monitoring of Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL). j. Monitor vital signs per Physician/Healthcare Practitioner orders or per HH Agency policy. 17. The private duty nurse will consult and collaborate with the participant's PCP, specialist, other team members, and primary care giver/family, for the purpose of evaluation of the participant and/or			

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

The private duty nurse must perform an initial comprehensive assessment for each participant. The comprehensive assessment will comply with all Federal, State, HH Agency and MFW regulations. The comprehensive assessment must be done at least annually and when clinically indicated. The assessment will be used to develop and revise the strategies, nursing plan of care, goals, and outcomes for the participant. The comprehensive assessment will include at least the following: 1. Review of the pertinent medical history 2. Medical and physical status 3. Cognitive status 4. Home and community environments for safety 5. Sensory status/perceptual processing 6. Environmental access skills 7. Instrumental activities of IADL and ADL techniques to improve deficits or effects of deficits 8. Mental status 9. Types of services and equipment required 10. Activities permitted 11. Nutritional status 12. Identification of nursing plans or goals for care.			

TAG # MF22.1 Private Duty Nursing – Scope of Services – IDT Meetings			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 **PRIVATE DUTY NURSING** All waiver recipients are eligible to receive in-home private duty nursing (PDN) services by a registered nurse (RN) or licensed practical nurse (LPN) per capped units/hours determined by approved Level of Care (LOC) Abstract, and when nursing is identified as a need on the Individual Service Plan (ISP). Under the direction of the participant's Physician(s)/Healthcare Practitioner and in conjunction with the Case Manager (CM), participant and the primary caregiver, the private duty nurse will develop and implement a nursing care plan that is <u>separate</u> from the ISP. PDN services for Medically Fragile Waiver (MFW) participants under the age of 21 are funded through the Medicaid Early Periodic Screening, Diagnostic & Treatment (EPSDT) program. This service standard is intended for the MFW participant 21 years and older. I. **<u>SCOPE OF SERVICE</u>** D. IDT Meeting Includes: 1. The HH Agency's RN supervisor is the HH Agency's representative at the IDT meeting if the supervising nurse is unable to attend in person of by conference call. 2. If unable to attend the IDT meeting, the nurse is expected to submit recommended updates to the strategies, nursing plan of care, goals and objectives in advance of the meeting for	Based on record review, the agency failed to assure that the Home Health Agency's RN supervisor or designee attended the IDT meeting for 6 of 6 individuals. • No documentation found to indicate attendance/representation of the RN at the IDT meeting (Individuals #2, 3, 4, 5, 6, 7)	**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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

the team's consideration. The nurse and CM will follow up after the IDT meeting to update the nurse on decisions and specific issues. 3. The agency nurse or designee must document in the participant's HH Agency file the date, time and coordination of any changes to strategies, nursing care plans, goals and objectives as a result of the IDT meeting. 4. Only one nurse representative per agency or discipline will be reimbursed for the time of the IDT meeting. The agency nurse representative must attend physically or telephonically in order to be reimbursed. 5. The HH Agency nurse is responsible for signing the IDT sign-in sheet. 6. Annually, and as needed, the agency RN may need to assist the CM with justification documentation supporting the modification to the approved budget (MAD 046 form). 7. PDN services do not start until there is an approved MAD 046 form for nursing.			

TAG # MF23 Agency/Individual Requirements			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 1/01/2011 **Private Duty Nursing** **II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS** E. Requirements for the HH Agency serving the Medically Fragile Waiver Population: 1. A RN or LPN in the state of New Mexico must maintain current licensure as required by the State of New Mexico Board of Nursing. The HH Agency will maintain verification of current licensure. Nursing experience in the area of developmental disabilities and/or medically fragile conditions is preferred. 2. When the HH Agency deems the nursing applicant's experience does not meet MFW Standard, then the applicant can be considered for employment by the agency if he/she completes an approved internship or similar program. The program must be approved by the MFW Manager and the Human Services Department (HSD) representative. 3. The supervision of all HH Agency personnel is the responsibility of the HH Agency Administrator or Director. 4. The HH Agency Nursing Supervisor(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN and Home Health Aide (HHA). 5. The HH Agency staff will be culturally sensitive to the needs and preferences of the participant/participant representative and households. Arrangement of written or	Based on record review the Agency did not ensure documented monthly contact that reflects the discussion and review of services and ongoing coordination of care for 6 of 6 Individuals reviewed. **Review of the Agency file revealed no evidence of monthly contact between the case manager and direct service provider:** • Individual #2: Not found for 1/2018, 2/2018, 5/2018, 6/2018. • Individual #3: None found for 11/2017, 1/2018, 2/2018, 5/2018, 6/2018. • Individual #4: Not found for 1/2018, 2/2018, 4/2018, 5/2018, 6/2018, 8/2018. • Individual #5: Not found for 1/2018, 2/2018, 4/2018, 5/2018, 6/2018. • Individual #6: Not found for 11/2017 – 2/2018 and 4/2018 – 10/2018. • Individual #7: Not found for 11/2017 – 2/2018 and 4/2018 – 10/2018.	**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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

spoken communication in another language may need to be considered. 6. The HH Agency will document and report any noncompliance with the ISP to the CM. 7. All Physician/Healthcare Practitioner orders that change the participant's LOC will be conveyed to the CM for coordination with service providers and modification to the ISP/budget if necessary. 8. The HH Agency will document in the participant's clinical file RN supervision to occur at least every sixty (60) days. Supervisory forms must be developed and implemented specifically for this task. 9. The HH Agency and CM must have documented monthly contact that reflects the discussion and review of services and ongoing coordination of care. 10. The HH Agency supervising RN, direct care RN, and LPN shall train the participant, family, direct support professional (DSP) and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments, use of equipment and technologies, or other areas of concern. 11. It is expected that the HH Agency will consult with the participant, IDT members, guardians, family and DSP as needed. **Home Health Aide (HHA)** **II. <u>AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS</u>** D. Requirements for the HH Agency Serving Medically Fragile Waiver Population: 1. The HH Agency nursing supervisors(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN and HHA. 2. The HH Agency staff will be culturally			

sensitive to the needs and preferences of participants and households. Arrangement of written or spoken communication in another language may need to be considered. 3. The HH Agency will document and report any noncompliance with the ISP to the case manager. 4. All Physician orders that change the participants service needs should be conveyed to the CM for coordination with service providers and modification to ISP/MAD 046 if necessary. 5. The HH Agency will document in the participant's clinical file that the RN supervision of the HHA occurs at least once every sixty days. Supervisory forms must be developed and implemented specifically for this task. 6. The HH Agency and CM must have documented monthly contact that reflects the discussion and review of services and ongoing coordination of care. 7. The HH Agency supervising RN, direct care RN and LPN shall train families, direct support professionals and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments, use of equipment and technologies or other areas of concern. 8. It is expected the HH Agency will consult with, Interdisciplinary Team (IDT) members, guardians, family, and direct support professionals (DSP) as needed.			

TAG #MF 1A28.2 Incident Mgt. System-Parent / Guardian Training			
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. E. **Consumer and Guardian Orientation Packet:** Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 3 of 6 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: **Parent/Guardian Incident Management Training (Abuse, Neglect and Exploitation)**: • Not Found (#2, 3) • Signed acknowledgement on 9/11/2011 not current to NMAC 7.1.14. (#6)	**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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Agency Personnel Requirements:			
Tag #MF 1A26 Consolidated On-line Registry / Employee Abuse Registry			
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.	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 4 of 4 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** • #200 – Date of hire 10/7/2014, completed 10/25/2016. • #201 – Date of hire 10/7/2014, completed 1/25/2016. • #202 - Date of hire 10/7/2014, completed 1/25/2016. • #203 - Date of hire 6/3/2016, completed 8/22/2016.	**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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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 reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. 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. 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. [7.1.12.8 NMAC - N, 01/01/2006]			

TAG #MF 1A28.1 Incident Mgt. System-Personnel Training			
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **B. Training curriculum:** Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer. **C. Incident management system training curriculum requirements:** **(1)** The community-based service provider shall conduct training or designate a knowledgeable	Based on record review and interview, the Agency did not ensure Incident Management Training for 3 of 15 Agency Personnel. **Review of the Agency personnel files revealed the following was not found and/or not current:** • Incident Management Training (Abuse, Neglect & Exploitation) (#210, 213) **When DSP were asked to give examples of Abuse, Neglect and Exploitation, the following was reported:** • DSP #200 – Example of Exploitation; stated "I don't know."	**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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	

representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to: **(a)** an overview of the potential risk of abuse, neglect, or exploitation; **(b)** informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths; **(d)** specific instructions on how to respond to abuse, neglect, or exploitation; **(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury. **(2)** All current employees and volunteers shall receive training within 90 days of the effective date of this rule. **(3)** All new employees and volunteers shall receive training prior to providing services to consumers. **D. Training documentation:** All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in			

this rule. **NMAC 7.1.13.10** **INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.			

TAG # MF27.1 RN Supervision Requirements			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 1/01/2010 **HOME HEALTH AIDE (HHA) II. <u>AGENCY / INDIVIDUAL PROVIDER REQUIREMENTS</u>** B. HHA Qualifications: 5. The HHA will be supervised by the HH Agency RN supervisor or HH Agency RN designee at least once every 60 days in the participant's home. 6. The HHA will be culturally sensitive to the needs and preferences of the participants and their families. Based upon the individual language needs or preferences, HHA may be requested to communicate in a language other than English. C. All supervisory visits/contacts must be documented in the participant's HH Agency clinical file on a standardized form that reflects the following: 1. Service received 2. Participant's status 3. Contact with family members 4. Review of HHA plan of care with appropriate modification annually and as needed D. Requirements for the HH Agency Serving Medically Fragile Waiver Population: 1. The HH Agency nursing supervisor(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN and HHA. 2. The HH Agency supervising RN, direct care	Based on record review and interview, the agency did not ensure the Home Health Aide and/or Private Duty Nurse was supervised by the Home Health Agency RN as required by standards for 5 of 6 individuals. **Review of the Agency individual case files revealed no evidence of RN supervisory visits occurring every 60 days for the following:** • Individual #2 - None found for 9/2018. • Individual #3 - None found for 01/2018. • Individual #4 - None found for 08/2018. • Individual #6 - None found for 02/2018, 06/2018 and 08/2018. • Individual #7 - None found for 06/2018, 08/2018 and 10/2018. **When Home Health Aides were asked how often they meet with their supervisor, the following was reported:** • #203 stated, "Initially but doesn't meet with (#214) on a regular scheduled time unless she needs to talk to her."	**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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

RN and LPN shall train families, direct support professionals and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments, use of equipment and technologies or other areas of concern. **Private Duty Nursing: II. <u>AGENCY / INDIVIDUAL PROVIDER REQUIREMENTS</u>** A. Requirements for the HH Agency serving the Medically Fragile Waiver Population: 1. A RN or LPN in the state of New Mexico must maintain current licensure as required by the State of New Mexico Board of Nursing. The HH Agency will maintain verification of current licensure. Nursing experience in the area of developmental disabilities and/or medically fragile conditions is preferred. 2. When the HH Agency deems the nursing applicant's experience does not meet MFW Standard, then the applicant can be considered for employment by the agency if he/she completes an approved internship or similar program. The program must be approved by the MFW Manager and the Human Services Department (HSD) representative. 3. The supervision of all HH Agency personnel is the responsibility of the HH Agency Administrator or Director. 4. The HH Agency Nursing Supervisor(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN and Home Health Aide (HHA). 5. The HH Agency staff will be culturally sensitive to the needs and preferences of the participant/participant representative			

and households. Arrangement of written or spoken communication in another language may need to be considered. 6. The HH Agency will document and report any noncompliance with the ISP to the CM. 7. All Physician/Healthcare Practitioner orders that change the participant's LOC will be conveyed to the CM for coordination with service providers and modification to the ISP/budget if necessary. 8. The HH Agency will document in the participant's clinical file RN supervision to occur at least every sixty (60) days. Supervisory forms must be developed and implemented specifically for this task. 9. The HH Agency and CM must have documented monthly contact that reflects the discussion and review of services and ongoing coordination of care. 10. The HH Agency supervising RN, direct care RN, and LPN shall train the participant, family, direct support professional (DSP) and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments, use of equipment and technologies, or other areas of concern. 11. It is expected that the HH Agency will consult with the participant, IDT members, guardians, family and DSP as needed. **NMAC 7.28.2.30.7** Annual Performance Review: A performance review, including written evaluation and skills demonstration must be completed on each home health aide no less frequently that every twelve (12) months.			

TAG # MF28 Home Health Aide – Administrative Requirements			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 1/01/2010 **HOME HEALTH AIDE (HAA)** **III. <u>ADMINISTRATIVE REQUIREMENTS</u>** The administrative requirements are directed at the HH Agency, Rural Health Clinic or Licensed or Certified Federally Qualified Health Center. A. The HH Agency will maintain licensure as a HH Agency, Rural Health Clinic or Federally Qualified Health Center, or maintain certification as a Federally Qualified Health Center. B. The HH Agency will assure that HHA services are delivered by an employee meeting the educational, experiential and training requirements as specified in the Federal 42 CFT 484.36 or State 7 NMAC 28.2. C. Copies of the CNA certificates must be requested by the employer and maintained in the personnel file of the HHA. D. The HH Agency will implement HHA care activities/plan of care per the participant's ISP identified strengths, concerns, priorities and outcomes. E. A HH Agency may consider hiring a participant's family member to provide HHA services if no other staff are available. The intent of the HHA service is to provide support to the family, and extended family should not circumvent the natural family support system. F. A participant's spouse or parent, if the	Based on record review and interview the Agency did not maintain an emergency backup plan for medical needs and staffing which was developed, written and agreed upon by the agency and participant/participant representative for 2 of 2 Individuals. **Review of individual case file revealed the following item was not found:** • Emergency backup plan (#3, 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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

participant is a minor child, shall not be considered as a HHA. G. The HHA is not a primary care giver, therefore when the HHA is on duty, there must be an approved primary caregiver available in person. The participant and/or representative and agency have the responsibility to assure there is a primary caretaker available in person. The primary caregiver must be available on the property where the participant is currently located and within audible range of the participant and HHA. H. All designated primary caretakers' names and phone numbers must be written in the backup plan and agreed upon by the agency and representative. The designated approved back up primary caregiver will not be reimbursed by the MFW/DDSD. I. An emergency backup plan for medical needs and staffing must be developed, written and agreed upon by the HH Agency and participant/participant representative. The emergency backup plan will be available in participant's home. The plan will be modified when medical conditions warrant and will be reviewed at least annually.			

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Administrative Requirements:			
TAG #MF 1A28 Incident Mgt. System			
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **B. Training Curriculum:** The licensed health care facility and community based service provider shall provide all employees and volunteers with a written training curriculum on incident policies and procedures for identification, and timely reporting of abuse, neglect, misappropriation of consumers' property, and where applicable to community based service providers, unexpected deaths or other reportable incidents, within thirty (30) days of the employees' initial employment, and by annual review not to exceed twelve (12) month intervals. The training curriculum may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the licensed health care facilities or community based service provider's facility. Training shall be conducted in a language that is understood by the employee and volunteer. C. **Incident Management System Training Curriculum Requirements:**	Based on record review and interview, the Agency did not establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. **During on-site survey, the following was found:** • No Incident Management Policy and Procedure was found. **When Agency Personnel were asked if the Agency has an Incident Management Quality Improvement Policy and Procedure, the following was reported:** • #214 stated, "We do not have a separate Policy/Procedure for Incident Management."	**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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

(1) The licensed health care facility and community based service provider shall conduct training, or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum that includes but is not limited to: **(a)** An overview of the potential risk of abuse, neglect, misappropriation of consumers' property; **(b)** Informational procedures for properly filing the division's incident management report form; **(c)** Specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and misappropriation of consumers' property. **(d)** Specific instructions on how to respond to abuse, neglect, misappropriation of consumers' property; **(e)** Emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, misappropriation of consumers' property; and **(f)** Where applicable to employees of community based service providers, informational procedures for properly filing the division's incident management report form for unexpected deaths or other reportable incidents.			

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Medicaid Billing/Reimbursement:			
TAG # MF25 Private Duty Nursing – Reimbursement			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 1/01/2011 **Private Duty Nursing: IV. <u>REIMBURSEMENT</u>** Each provider of a service is responsible for providing clinical documentation that identifies the DSP's role in all components of the provision of home care: including assessment information, care planning, intervention, communications and care coordination and evaluation. There must be justification in each participant's medical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of care. Services must be reflected in the ISP that is coordinated with the participant/participant's representative, other caregivers as applicable, and authorized by the approved budget. All services provided, claimed and billed must have documented justification supporting medical necessity and be covered by the MFW. A. Payment for PDN services through the Medicaid waiver is considered payment in full. B. PDN services must abide by all Federal, State and HSD and DOH policies and procedures regarding billable and non-billable items. C. Billed services must not exceed the capped dollar amount for LOC.	Based on record review, the Agency did not provide written or electronic documentation as evidence for each hour billed for Private Duty Nursing Services for 1 of 4 individuals. Individual # 6 July 2018 • The Agency billed a total of 20 units of Private Duty Nursing Services (T1003 U1) on 7/6/2018. Documentation found accounted for 19 units.	**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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

D. PDN services are a Medicaid benefit for children birth to 21 years, through the children's EPSDT program. E. The Medicaid benefit is the payer of last resort. Payment for the PDN services should not be requested until all other third-party and community resources have been explored and/or exhausted. F. PDN services are a MFW benefit for the 21 year and older enrolled participant. The MFW benefit is the payer of last resort. Payment for waiver services should not be requested or authorized until all other third-party and community resources have been explored and/or exhausted. G. Reimbursement for PDN services will be based on the current rate allowed for services. H. The HH Agency must follow all current billing requirements by the HSD and DOH for PDN services. I. Service providers have the responsibility to review and assure that the information on the MAD 046 form for their services is current. If providers identify an error, they will contact the CM or a supervisor of the case. 1. The private duty nurse may ride in the vehicle with the participant for the purpose of oversight, support or monitoring during transportation. The private duty nurse may not operate the vehicle for the purpose of transporting the participant. J. The MFW Program does not consider the following to be professional PDN duties and will not authorize payment for: 1. Performing errands for the participant/participant representative or family that is not program specific. 2. "Friendly visiting," meaning visiting with			

the participant outside of PDN work scheduled. 3. Financial brokerage services, handling of participant finances or preparation of legal documents. 4. Time spent on paperwork or travel that is administrative for the provider. 5. Transportation of participants. 6. Pick up and/or delivery of commodities. 7. Other non-Medicaid reimbursable activities.			

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date: April 2, 2019

To: Jennie Osness, Quality Assurance Manager
Provider: Harmony Home Health, Limited Liability Company
Address: 5700 S. Harper Dr. NE, Suite 280
State/Zip: Albuquerque, New Mexico 88109

E-mail Address: jennieo@harmonyhomehealth.com

CC: Anitha Thomisee, RN, Pediatric Case Manager - Supervisor
Address: 5700 S. Harper Dr. NE, Suite 280
State/Zip: Albuquerque, New Mexico 88109

E-Mail Address: anithat@harmonyhomehealth.com

Region: Metro
Survey Date: November 2 – 8, 2018
Program Surveyed: Medically Fragile Waiver

Service Surveyed: Respite Home Health Aide and Respite Private Duty Nursing

Survey Type: Routine

Dear Ms. J. Osness:

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

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