Date:	February 14, 2019
To:	Liza Barbee, Executive Director
Provider:	Mountain Shadows Home Care, Inc.
Address:	800 N. Telshor Suite B
State/Zip:	Las Cruces, New Mexico 88011
E-mail Address:	liza@mountainshadowshomecare.com
CC:	Grey Handy, Board Chair
Address:	44 Brass Horse Rd.
State/Zip:	Santa Fe, New Mexico 87508
Board Chair E-Mail Address	greyhandy@gmail.com
Region:	Southwest
Survey Dates:	December 3 - 7, 2018
Program Surveyed:	Medically Fragile Waiver
Services Surveyed:	Home Health Aide (HHA), Private Duty Nursing (PDN), Respite HHA and Respite PDN
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, Nurse Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau and Iris Clevenger, RN, BSN, MA, CCM, Medically Fragile Waiver Program Manager, Developmental Disability Supports Division/Clinical Services Bureau

Dear Ms. L. Barbee:

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:	December 3, 2018
Contact:	**Mountain Shadows Home Care, Inc.** Liza Barbee, Executive Director **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Deputy Bureau Chief / Team Lead
On-site Entrance Conference Date:	December 4, 2018
Present:	**Mountain Shadows Home Care, Inc.** Liza Barbee, Executive Director Theresa Hinojosa, RN, Director of Nursing Erika Guerrero, LPN, Assistant Director of Nursing **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Deputy Bureau Chief / Team Lead Yolanda J. Herrera, RN, Nurse Healthcare Surveyor
Exit Conference Date:	December 7, 2018
Present:	**Mountain Shadows Home Care, Inc.** Liza Barbee, Executive Director Theresa Hinojosa, RN, Director of Nursing Erika Guerrero, LPN, Assistant Director of Nursing **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Deputy Bureau Chief / Team Lead Yolanda J. Herrera, RN, Nurse Healthcare Surveyor **DDSD** Iris Clevenger, RN, BSN, MA, CCM, Medically Fragile Waiver Program Manager, Developmental Disability Supports Division/Clinical Services Bureau (via phone)
Administrative Locations Visited	Number: 2 (800 N. Telshor Las Cruces, New Mexico 88011 & 1015 Cuba Ave. Alamogordo, New Mexico 88310)
Total Sample Size	Number: 7 2 - Home Health Aide 4 - Respite Home Health Aide 2 - Private Duty Nursing 2 - Respite Private Duty Nursing
Total Homes Visited	Number: 6 (Two Individuals live in the same residence.)
Persons Served Records Reviewed	Number: 7
Recipient/Family Members Interviewed	Number: 6 (Two Individuals on the sample were siblings and the same family member was interviewed.)

Home Health Aide Records Reviewed	Number:	13
Home Health Aide (HHA) Interviewed	Number:	6
Private Duty Nursing Records Reviewed	Number:	22
Private Duty Nursing Interviewed	Number:	3 (Two Individuals on the sample were siblings and live in the same residence. One of the nurses was interviewed for both.)
Administrative Personnel Interviewed	Number:	4

Administrative Files Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Internal Incident Management Reports and System Process
- Agency Policy and Procedure to include, but not limited to:
    - Transportation of individuals served.
    - Employee Tuberculosis Testing.
    - Rights and Responsibilities and Grievance Procedure.
    - Transition/discharges/termination of individuals served.
    - Procedures for disaster planning and emergency preparedness and evacuation of individuals served.
    - Response to individual's medical emergency situations.
    - Record Storage for maintaining individual's files.
    - Supervision of HHAs, LPNs, RNs and verification process to ensure competency.
- 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: **Mountain Shadows Home Care, Inc.** - **Southwest Region**
Program: Medically Fragile Waiver
Services: Home Health Aide (HHA), Private Duty Nursing (PDN), Respite HHA and Respite PDN
Survey Type: Routine
Survey Dates: **December 3 - 7, 2018**

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Agency Record Requirements:			
TAG # MF05.1 Documentation Requirements – Agency Case Files			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 **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 8. Pharmacy b. Individual's health plan, if appropriate c. Individual's current ISP	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 5 of 7 Individuals. Review of the Agency's Individual case files revealed the following items were not found and / or incomplete: **Home Health Aide Progress Notes:** • Individual #5 – Progress note not found for 8/30/2018. • Individual #6 – Progress note not found for 8/2, 3, 2018. • Individual #5 – No staff signature and title for each date of encounter and description of services for August 2018, September 2018 and October 2018. (*Note: Progress notes only included one staff signature for a week of billing and used check boxes to document description of services. Per MFW standards / regulations each unit billed should include a signature and title of staff providing the services and a description of what occurred during the encounter or services to justify billable time*.)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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 most recent 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 serviced encounter or other billable service interval. b. A description of what occurred during the encounter or service interval.	• Individual #6 – No staff signature and title for each date of encounter and description of services for August 2018, September 2018 and October 2018. (*Note: Progress notes only included one staff signature for a week of billing and used check boxes to document description of services Per MFW standards / regulations each unit billed should include a signature and title of staff providing the services and a description of what occurred during the encounter or services to justify billable time*.) **Respite Home Health Aide Progress Notes:** • Individual #1 – No staff signature and title for each unit billed for August 2018, September 2018 and October 2018. (*Note: Progress notes only included one staff signature for a week of billing. Per MFW standards / regulations each unit billed should include a signature and title of staff providing the services to justify billable time*.) • Individual #3 – No staff signature and title for each date of encounter and description of services for August 2018, September 2018 and October 2018. (*Note: Progress notes only included one staff signature for a week of billing and used check boxes to document description of services. Per MFW standards / regulations each unit billed should include a signature and title of staff providing the services and a description of what occurred during the encounter or services to justify billable time*.) • Individual #7 – No staff signature and title for each unit billed for August 2018, September		

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 regulations.	2018 and October 2018. (*Note: Progress notes only included one staff signature for a week of billing. Per MFW standards / regulations each unit billed should include a signature and title of staff providing the services to justify billable time.)*		

TAG # MF 10.1 Secondary FOC			
Appendix D: Participant Centered Planning and Service Delivery – Medically Fragile Waiver Application D. IDT Meeting and ISP Development and Budget Development (MAD 046 form): 1. The participant/participant representative will have the opportunity to be involved in all aspects of the ISP. 2. The purpose of IDT meetings is to develop the ISP, review effectiveness of the ISP and revise the ISP. 3. In preparation for an IDT meeting, the CM will offer the participant/participant representative a menu of waiver services as appropriate and will document selected services. 4. The IDT will be comprised of the participant/participant representative, the PCP and all MFW providers and external providers. The MFW providers are expected to attend ISP meetings and all others are encouraged to attend. 5. The participant/participant representative will choose a provider from the MFW secondary freedom of choice (SFOC) list. Each service listed on the MAD 046 form has a separate SFOC. 6. The participant/participant representative is encouraged to contact provider agencies and interview the agency and potential providers. For private duty nursing (PDN) services, the participant/participant representative will meet with the potential Home Health Agency representative to discuss specific	Based on record review, the Agency did not maintain the Secondary Freedom of Choice documentation relevant to the services their agency provided for 1 of 7 Individuals. **Review of the Agency's Individual case files revealed Secondary Freedom of Choices were not found and/or not agency specific for the following:** • Home Health Aide (#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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

needs and skills that will be expected from the nurse and/or home health aide in an effort to match nurse and/or home health aide with the participant and family. The participant/participant representative has the final say in who provides services based on available choice. The participant/participant representatives' signature on the SFOC indicates their choice of provider agency for a specific service. 7. When the participant is under the age of 21 years, Early Periodic Screening, Diagnostic & Treatment (EPSDT) services will be provided by the State Medicaid Plan. The CM will facilitate the choice of provider agency based on the network. The participant/participant representative has the final say on who provides services based on available choices.			

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 <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>** 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 LPN employed by the chosen	Based on record review, the Agency did not maintain complete documentation of private duty nursing scope of service for 5 of 7 Individuals served. **Review of the Agency's Individual case files revealed the following items were not found, incomplete, and/or not current:** **Annual Comprehensive Assessment:** • Not Found (#2, 4, 5, 6) **CMS-485 60 Day Review/Renewal:** • Individual #3 – Not found for the following certification periods 10/2017, 12/2017, 2/2018 and 4/2018. • Individual #4 – Not found for the following certification periods 11/2017 and 1/2018. • Individual #6 – Not found for the following certification period 11/2017. • Individual #3 - Certification periods not renewed by PCP every 60 days as required. CMS-485 certification period for 4/21/2018 – 6/19/2018 not signed until 5/18/2018. • Individual #5 – Certification periods not renewed by PCP every 60 days as required. CMS-485 signed by PCP on 9/15/2017; next certification period not signed until 3/24/2018. • Individual #6 – Certification periods not renewed by PCP every 60 days as required.	**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?)*: →	

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 documentation requirements of the MFW,	CMS-485 signed by PCP on 8/31/2018; next certification period not signed until 11/16/2018. **60-Day Medication Review by RN Supervisor or RN Designee:** • Individual #4 – Not found for 1/2018, 5/2018, 7/2018, 9/2018. • Individual #5 – Not found for 4/2018. • Individual #6 – Not found for 5/2018, 7/2018, 9/2018.		

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 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** 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 the team's consideration. The nurse and CM	Based on record review, the Agency failed to ensure that the HH Agency's RN supervisor or designee attended the IDT meeting for 4 of 7 Individuals. • No documentation found to indicate the RN supervisor or designee attended the IDT meeting. (Individuals #3, 4, 5, 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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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 Private Duty Nursing – 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 spoken communication in another language may need to be considered.	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 4 of 7 Individuals reviewed. **Review of Agency's case files revealed no evidence of monthly contact between the case manager and direct service provider for the following:** • Individual #3 – Not found for 11/2017 - 3/2018, 6/2018, 10/2018. • Individual #4 – Not found for 10/2017 - 5/2018, 9/2018 - 11/2018. • Individual #5 – Not found for 10/2017 - 3/2018. • Individual #6 – Not found for 10/2017 - 3/2018.	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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.			

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Agency Personnel Requirements:			
Tag # MF 1A25 **Criminal Caregiver History Screening**			
NMAC 7.1.9.9 **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. [7.1.9.9 NMAC - Rp, 7.1.9.9 NMAC, 01/01/06] **NMAC 7.1.9.11** **DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection. [7.1.9.9 NMAC - Rp, 7.1.9.9 NMAC, 01/01/06]	Based on record review, the Agency did not maintain documentation indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 1 of 13 Agency Personnel. **The following Agency Personnel file contained no evidence of Caregiver Criminal History Screening:** • #229 – Date of hire 9/6/2013.	**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 #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. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an	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 13 Agency Personnel. **The following Agency Personnel file contained no evidence of the Employee Abuse Registry check being completed:** • #229 – Date of hire 9/6/2013. **The following Agency Personnel files contained evidence that indicated the Employee Abuse Registry check was completed after hire:** • #224 – Date of hire 10/8/2014, completed 4/12/2018. • #226 – Date of hire 6/6/2017, completed 6/25/2018. • #233 – Date of hire 8/20/2008, completed 7/2/2014.	**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?)*: →	

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.	Based on record review and interview, the Agency did not ensure Incident Management Training for 35 of 35 Agency Personnel. **Review of the Agency's Personnel files revealed the following was not found and/or not current:** Incident Management Training (Abuse, Neglect & Exploitation): • Not found (#215, 218, 219, 221, 222, 223, 227, 229, 234) • Not current (#200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 216, 217, 220, 224, 225, 226, 228, 230, 231, 232, 233) *Note: Annual ANE training for staff had been updated, however, the training was not inclusive of the current NMAC 7.1.14 regulations.* **When Direct Support Personnel (DSP) were asked what State Agency must be contacted when there is suspected Abuse, Neglect and Exploitation, the following was reported:** • DSP #224 stated, "Police." Staff was not able to identify the State Agency as Division of Health Improvement. • DSP #227 stated, "Michele at agency." Staff was not able to identify the State Agency as Division of Health Improvement.	**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?)*: →	

C. Incident management system training curriculum requirements: **(1)** The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to: **(a)** an overview of the potential risk of abuse, neglect, or exploitation; **(b)** informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths; **(d)** specific instructions on how to respond to abuse, neglect, or exploitation; **(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury. **(2)** All current employees and volunteers shall receive training within 90 days of the effective date of this rule. **(3)** All new employees and volunteers shall receive training prior to providing services to consumers. **D. Training documentation:** All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain	• DSP #228 stated, "Mountain Shadows and fill it out there." Staff was not able to identify the State Agency as Division of Health Improvement. • DSP #231 stated, "I don't know." Staff was not able to identify the State Agency as Division of Health Improvement. **When DSP were asked to give examples of Abuse, Neglect and Exploitation, the following was reported:** • DSP #224 stated, "I don't know." When asked to give an example of Exploitation. • DSP #232 stated, "I don't know." When asked to give an example of Exploitation.		

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 # MF26 Agency Personnel Requirements – Tuberculosis Testing			
NMAC 7.28.2.37.1.5: Health certificate for all staff having contact with patient/clients stating that the employee is free from tuberculosis in a transmissible form as required by the Infectious Disease Bureau, of the Public Health Division, Department of Health.	Based on record review, the Agency did not maintain Health certificate for all staff having contact with patient/clients stating that the employee is free from tuberculosis for 14 of 35 Agency Personnel. **Review of the Agency's Personnel files revealed the following was not found:** • Tuberculosis Testing – Two Step (#204, 207, 216, 229, 230, 233, 234)	**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 # MF27 Agency / Individual Provider 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>** A. The HH Agency must be a current MFW provider with the Provider Enrollment Unit (PEU)/Developmental Disabilities Supports Division (DDSD). B. HHA Qualifications: 1. HHA Certificate from an approved community based program following the HHA training Federal regulations 42 CFR 484.36 or the State Regulation 7 NMAC28.2, or 2. HHA training at the licensed HH Agency which follows the Federal HHA training regulation in 42 CFR 484.36 or the State Regulation 7 NMAC28.2, or, 3. A Certified Nurses' Assistant (CNA) who has successfully completed the employing HH Agency's written and practical competency standards and meets the qualifications for a HHA with the MFW. Documentation will be maintained in personnel file. 4. A HHA who was not trained at the employing HH Agency will need to successfully complete the employing HH Agency's written and practical competency standards before providing direct care services. Documentation will be maintained in personnel file.	Based on record review, the Agency did not maintain documentation indicating ongoing training and evidence of completion of practical competency standards for 14 of 35 agency personnel. **Review of the Agency's Personnel files revealed the following was not found:** **Training Requirements:** • 12 hours of Annual In-Service Training (#222, 223, 224, 226, 227, 228, 230, 234) • CPR (#223, 225, 226) **Personnel Requirements:** • Annual Performance Reviews (#223, 234)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

5. 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 staff will be culturally sensitive to the needs and preferences of participants and households. Arrangements 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 participant's 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 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. **NMAC 7.28.2.37.1.5** Health certificate for all staff having contact with patient/clients stating that the employee is free from tuberculosis in a transmissible form as required by the Infectious Disease Bureau, of the Public Health Division, Department of Health. **NMAC 7.28.2.30.3.1** Home Health Aides: The home health aide training program must address each of the subject areas listed below. 30.3.1. H Recognizing emergencies and			

knowledge of emergency procedures including CPR and first aid). **NMAC 7.28.2.30.6** Annual In-Service Training: Each home health aide must participate in at least twelve (12) documented hours of in-service training during each twelve (12) month period. This requirement may be fulfilled on a prorated basis during the home health aide's first year of employment at the home health agency. **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 # 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 RN and LPN shall train families, direct support professionals and all relevant	Based on record review, 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 7 of 7 Individuals. **Review of the Agency's Individual case files revealed RN supervisory visits with the Home Health Aide were missing all/or some required components for the following:** **Individual #1:** The following component was not found for 10/2017 - 10/2018. • Review of HHA plan of care with appropriate modification annually and as needed. **Individual #2:** The following component was not found for 1/2018 - 11/2018. • Review of HHA plan of care with appropriate modification annually and as needed. **Individual #3:** The following components were not found for 4/9/2018, 6/13/2018, 8/3/2018, 10/31/2018. • Service received. • Participant's status. • Review of HHA plan of care with appropriate modification annually and as needed. **Individual #4:** The following component were not found for 2/12/2018, 8/22/2018, 11/14/2018.	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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	• Service received. • Participant's status. Additionally, the following components were not found for 10/2017 - 10/2018. • Contact with family members. • Review of HHA plan of care with appropriate modification annually and as needed. **Individual #5:** The following components were not found for 3/12/2018, 5/17/2018, 7/13/2018, 9/12/2018, 11/7/2018. • Service received. • Participant's status. Additionally, the following components were not found for 10/2017 - 10/2018. • Review of HHA plan of care with appropriate modification annually and as needed. **Individual #6:** The following components were not found for 3/12/2018, 5/17/2018, 7/13/2018, 9/12/2018, 11/7/2018. • Service received. • Participant's status. Additionally, the following components were not found for 10/2017 - 10/2018. • Contact with family members. • Review of HHA plan of care with appropriate modification annually and as needed.		

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.	**Individual #7:** The following components were not found for 10/2017 - 11/2018. • Participant's status. • Review of HHA plan of care with appropriate modification annually and as needed. **When Home Health Aides were asked how often they meet with their supervisor, the following was reported:** • #228 stated, "Haven't seen him in a while." • #231 stated, "Only meet with Amelia if there was something unusual but not on a regular basis."		

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Administrative Requirements:			
TAG # MF103 CQI System			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 **GENERAL PROVIDER REQUIREMENTS:** I. Provider Requirements F. Program Flexibility: 1. If the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects conflicts with these standards, then prior written approval from the DOH shall be obtained. Such approval shall provide for the terms and conditions under which the waiver of specific standard(s) is/are granted. The applicant or provider agency is required to submit a written request and attach substantiating evidence supporting the request to DOH. DOH will only approve requests that remain consistent with the current federally approved MFW application. G. Continuous Quality Management System: 1. On an annual basis, MFW provider agencies shall update and implement the request, the agency will submit a summary of each year's quality improvement activities and resolutions to the MFW Program Manager.	Based on record review, the Agency did not implement their Continuous Quality Management System as required by standard. **No evidence of the agency's Quality Assurance/Quality Improvement Plan in order to assure the provisions of quality services.** **Review of the Quality Management Quarterly meetings revealed the following:** Quality Improvement Committee meetings did not occur as required. Review of meeting minutes found meetings were not occurring quarterly. • Last meeting minutes found were dated 7/26/2018.	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

NMAC 7.28.2.39 Quality Improvement: Each agency must establish an on-going quality improvement program to ensure an adequate and effective operation. To be considered on-going, the quality improvement program must document quarterly activity that addresses, but is not limited to: A. **Clinical Care:** Assessment of patient/client goals and outcome, such as, diagnosis (es), plan of care, services provided, and standards of patient/client care. B. **Operational activities:** Assessment of the total operation of the agency, such as, policies and procedures, statistical data (i.e., admission, discharges, total visits by discipline, etc.), summary of quality improvement activities, summary of patient/client complaints and resolution, and staff utilization. C. **Quality improvement action plan:** Written responses to address existing or potential problems which have been identified. D. **Documentation of activities:** The results of the quality improvement activities shall be compiled annually in report format and formally reviewed and approved by the governing body and advisory group of the home health agency. No more than one year may lapse between evaluations of the same part. E. The licensing authority may, at its sole discretion, request quarterly activity summaries of an agency's on-going quality improvement activities and /or may direct the agency to conduct specific quality improvement studies.			

TAG # MF04 General Provider Requirements			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 **GENERAL PROVIDER REQUIREMENTS** I. Provider Requirements A. The Medicaid Medically Fragile Home and Community Based Services Waiver requires providers to meet any pertinent laws, regulations, rules, policies and interpretive memoranda published by the New Mexico Department of Health (DOH) and HSD. B. All providers must be currently enrolled as a MFW provider through the Developmental Disabilities' Supports Division (DDSD) Provider Enrollment Unit process. Reference: http://nmhealth.org/ddsd/providerinformation/ProviderEnrollmentApplicationPage.htm C. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures. D. All provider agencies that enter into a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies and standards. Reference: http://dhi.health.state.nm.us/ E. Provider Agency Report of Changes in Operations: 1. The provider agency shall notify the DOH in writing of any changes in the disclosures required in this section within ten (10) calendar days. This notice shall include information and documentation	Based on record review, the Agency did not develop, implement and/or update written policies and procedures that comply with all DDSD requirements. **Review of Agency policies & procedures found no evidence of the following:** • A policy and procedure for response to individual emergency medical situations, including staff training for emergency response and on call systems as indicated with in scope of practice, including nursing on-call.	**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?)*: →	

regarding such changes as the following: any change in the mailing address of the provider agency, and any change in executive director, administrator and classification of any services provided. F. Program Flexibility: 1. If the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects conflicts with these standards, then prior written approval from the DOH shall be obtained. Such approval shall provide for the terms and conditions under which the waiver of specific standard(s) is/are granted. The applicant or provider agency is required to submit a written request and attach substantiating evidence supporting the request to DOH. DOH will only approve requests that remain consistent with the current federally approved MFW application. G. Continuous Quality Management System: 1. On an annual basis, MFW provider agencies shall update and implement the request, the agency will submit a summary of each year's quality improvement activities and resolutions to the MFW Program Manager. H. The provider agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and that comply with all DDSD policies and procedures and all relevant New Mexico statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.			

I. Appropriate planning shall take place with all Interdisciplinary Team (IDT) members, Medicaid SALUD provider, other waiver providers and school services to facilitate a smooth transition from the MFW program. The participant's individual choices shall be given consideration when possible. DOH policies must be adhered to during this process as per the provider's contract. J. All provider agencies, in addition to requirements under each specific service standard, shall at a minimum develop, implement and maintain at the designated provider agency main office, documentation of policies and procedures for the following: 1. Coordination with other provider agency staff serving individuals receiving MFW services that delineates the specific roles of each agency staff. 2. Response to the individual emergency medical situations, including staff training for emergency response and on-call systems as indicated. 3. Agency protocols for disaster planning and emergency preparedness.			

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:** **(1)** The licensed health care facility and community based service provider shall conduct	Based on record review, 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:** • The agency does not have a designated Incident Management Coordinator.	**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?)*: →	

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 # MF29 Home Health Aide – Reimbursement			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 1/01/2010 **Home Health Aide (HHA) IV. REIMBURSEMENT:** Each provider of a service is responsible for providing clinical documentation that identifies direct care professional (DCP) roles 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 clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant's representative and other caregivers as applicable. All services provided, claimed and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget. A. Payment for HHA services through the Medicaid Waiver is considered payment in full. B. The HHA services must abide by all Federal, State, HSD and DOH policies and procedures regarding billable and non-	Based on record review, the Agency did not provide written or electronic documentation as evidence for each hour billed for Home Health Aide visits for 2 of 7 Individuals. Individual #5: August 2018 • The Agency billed 2 hours of Home Health Aide Services (S9122) on 8/30/2018. No documentation found to account for billed hours. Individual #6: August 2018 • The Agency billed 2 hours of Home Health Aide Services (S9122) on 8/2/2018. No documentation found to account for billed hours. • The Agency billed 2 hours of Home Health Aide Services (S9122) on 8/3/2018. No documentation found to account for billed hours.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

billable items. C. The billed services must not exceed capped dollar amount for LOC. D. The HHA services are a Medicaid benefit for children birth to 21 years though the children's EPSDT program. E. The Medicaid benefit is the payer of last resort. Payments for HHA services should not be requested until all other third party and community resources have been explored and/or exhausted. F. Reimbursement for HHA services will be based on the current rate allowed for the service. G. The HH Agency must follow all current billing requirements by the HSD and the DOH for HHA services. H. Providers of service have the responsibility to review and assure that the information of the MAD 046 for their services is current. If the provider identifies an error, they will contact the CM or a supervisor at the case management agency immediately to have the error corrected. 1. The HHA may ride in the vehicle with the participant for the purpose of oversight during transportation. The HHA will accompany the participant for the purpose of monitoring or support during transportation. This means the HHA may not operate the vehicle for purpose of transporting the participant. I. The MFW Program does not consider the following to be professional HHA duties and will not authorize payment for: 1. Performing errands for the participant/participant's representative or family that is not program specific.			

2. “Friendly visiting”, meaning visits with the participant outside of 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 26, 2019

To: Liza Barbee, Executive Director
Provider: Mountain Shadows Home Care, Inc.
Address: 800 N. Telshor Suite B
State/Zip: Las Cruces, New Mexico 88011

E-mail Address: liza@mountainshadowshomecare.com

CC: Grey Handy, Board Chair
Address: 44 Brass Horse Rd.
State/Zip: Santa Fe, New Mexico 87508

Board Chair E-Mail Address: greyhandy@gmail.com

Region: Southwest
Survey Dates: December 3 - 7, 2018
Program Surveyed: Medically Fragile Waiver

Services Surveyed: Home Health Aide (HHA), Private Duty Nursing (PDN), Respite HHA and Respite PDN

Survey Type: Routine

Dear Ms. L. Barbee:

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

Q.19.2.MedFrag.D0706.3.RTN.09.19.116