NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DR. TRACIE C. COLLINS, M.D.
Secretary-Designate

Date:	January 15, 2021
To:	Jennie Osness, Quality Assurance Manager / Incident Management Coordinator
Provider:	Harmony Home Health, Limited Liability Company
Address:	5700 Harper Dr. NE, Suite 280
State/Zip:	Albuquerque, New Mexico 88109
E-mail Address:	jennieo@harmonyhomehealth.com
CC:	Anitha Thomisee, RN, Pediatric Case Manager - Supervisor
Address:	5700 Harper Dr. NE, Suite 280
State/Zip:	Albuquerque, New Mexico 88109
E-Mail Address:	anithat@harmonyhomehealth.com
Region:	Metro and Northeast
Survey Date:	December 7 - 18, 2020
Program Surveyed:	Medically Fragile Waiver (MFW)
Service Surveyed:	Home Health Aide (HHA), Private Duty Nursing (PDN), Respite HHA, Respite PDN
Survey Type:	Routine
Team Leader:	Yolanda J. Herrera, RN, Nurse Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Beverly Estrada, ADN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Monica Valdez, BS, Plan of Correction Coordinator and Healthcare Surveyor Advanced, Division of Health Improvement/Quality Management Bureau and Iris Clevenger, BSN, RN, CCM, MA, MFW Program Manager, Developmental Disabilities Supports Division/Clinical Services Bureau

Dear Ms. J. Osness:

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

The following Tags are identified deficiencies:

- Tag # MF05 General Provider Requirements: Provider Agency Case Files
- Tag # MF05.1 General Provider Requirements: Provider Agency Case Files – Documentation

- Tag # MF22 Private Duty Nursing: Scope of Services – Plans / Assessments
- Tag # MF22.1 Private Duty Nursing: Scope of Services – IDT Meetings
- Tag # MF23 Private Duty Nursing: Agency/Individual Requirements
- Tag # MF27.1 HHA and PDN: Agency/Individual Provider Requirements – RN Supervision
- Tag # MF28 Home Health Aide: Administrative Requirements – Emergency Backup Plan
- Tag # MF 1A28.2 Incident Management System / ANE Acknowledgement – Individual/Family/Guardian
- Tag # MF129 Complaints and Grievance Acknowledgement – Individual/Family/Guardian
- Tag # MF 1A25 Criminal Caregiver History Screening
- Tag # MF 1A26 Consolidated On-line Registry / Employee Abuse Registry
- Tag # MF 1A28.1 Incident Management System – Personnel Training
- Tag # MF24 Private Duty Nursing: Agency/Individual Provider Requirements
- Tag # MF26 Pre-employment – Tuberculosis Testing
- Tag # MF27 Home Health Aide – Agency/Individual Provider Requirements – Ongoing Training
- Tag # MF103 Continuous Quality Improvement System
- Tag # MF04 General Provider Requirements – Policies and Procedures
- Tag # MF 1A28 Incident Management System
- Tag # MF29 Home Health Aide Reimbursement

Plan of Correction:

The attached Report of Findings identifies the deficiencies found during your agency's on-site compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

You were provided information during the exit meeting portion of your on-site survey. Please refer to this information (Attachment A) for specific instruction on completing your Plan of Correction. At a minimum, your Plan of Correction should address the following for each Tag cited:

Corrective Action for Current Citation:

- How is the deficiency going to be corrected? (i.e. obtained documents, retrain staff, individuals and/or staff no longer in service, void/adjusts completed, etc.) This can be specific to each deficiency cited or if possible an overall correction, i.e. all documents will be requested and filed as appropriate.

On-going Quality Assurance/Quality Improvement Processes:

- What is going to be done on an ongoing basis? (i.e. file reviews, etc.)
- How many individuals is this going to effect? (i.e. percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e. weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position within your agency)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORA, etc.)
- How is this integrated in your agency's QIS, QI Committee reviews and annual report?

Submission of your Plan of Correction:

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

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

1. **Quality Management Bureau, Attention: Monica Valdez, Plan of Correction Coordinator 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108**
2. **Developmental Disabilities Supports Division, Attention: Medically Fragile Waiver Program Manager**

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as

soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.
Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Billing Deficiencies:

If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a "Void/Adjust" claim or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

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

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

*Lisa Medina-Lujan (*Lisa.medina-lujan@state.nm.us*)*

Please be advised that there is a one-week lag period for applying payments received by check to Void/Adjust claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.

Request for Informal Reconsideration of Findings (IRF):

If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

ATTN: QMB Bureau Chief
Request for Informal Reconsideration of Findings
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request/QMB

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

Please call the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 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,

Yolanda J. Herrera, RN

Yolanda J. Herrera, RN
Nurse Healthcare Surveyor / Team Lead
Division of Health Improvement / Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	December 7, 2020
Contact:	**Harmony Home Health, Limited Liability Company** Anitha Thomisee, RN Pediatric Case Manager/Supervisor **DOH/DHI/QMB** Yolanda J. Herrera, RN, Nurse Healthcare Surveyor / Team Lead
Entrance Date:	December 7, 2020
Present:	**Harmony Home Health, Limited Liability Company** Anitha Thomisee, RN, Pediatric Case Manager/Supervisor Angela Abeyta, RN, Pediatric Supervision Case Manager/Clinical Nurse Jennie Osness, QA Manager/Incident Management Coordinator Heather Mills, Harmony Home Health Director of Pediatrics **DOH/DHI/QMB** Yolanda J. Herrera, RN, Nurse Healthcare Surveyor / Team Lead Beverly Estrada, ADN, Healthcare Surveyor Lora Norby, Healthcare Surveyor Monica Valdez, BS, Plan of Correction Coordinator, Healthcare Surveyor Advanced **DDSD – Clinical Services Bureau** Iris Clevenger, RN, BSN, MA, CCM, MFW Program Manager
Exit Date:	December 18, 2020
Present:	**Harmony Home Health, Limited Liability Company** Anitha Thomisee, RN, Pediatric Case Manager/Supervisor Angela Abeyta, RN, Pediatric Supervision Case Manager/Clinical Nurse Jennie Osness, QA Manager/Incident Management Coordinator Heather Mills, Harmony Home Health Director of Pediatrics William David Stong, Harmony Home Health - VP of Finance Kari Domm, Harmony Home Health - CEO **DOH/DHI/QMB** Yolanda J. Herrera, RN, Nurse Healthcare Surveyor / Team Lead Lora Norby, Healthcare Surveyor
Administrative Locations Visited	0 *(Note: No administrative locations visited due to COVID-19 Pandemic Public Health Emergency)*
Total Sample Size:	7 1 – Home Health Aide 2 – Private Duty Nursing 3 – Respite Home Health Aide 3 – Respite Private Duty Nursing
Total Homes Visited:	0 *(Note: No home visits conducted due to COVID-19 Pandemic Public Health Emergency)*
Persons Served Records Reviewed:	7

Recipient/Family Members Interviewed:	6 *(Note: Interviews conducted by video / phone due to COVID- 19 Public Health Emergency. One Recipient/Family member was not available during the survey.)*
Home Health Aide Records Reviewed:	15
Home Health Aide Interviewed:	4
Private Duty Nursing Records Reviewed:	13
Private Duty Nursing Interviewed:	5 *(Note: Interviews conducted by video / phone due to COVID- 19 Public Health Emergency.)*
RN Supervisor Record Reviewed:	1
Administrative Personnel Interviewed:	4 *(Note: Interviews conducted by video / phone due to COVID- 19 Public Health Emergency. One Administrative Personnel interviewed also provides services as the RN Supervisor.)*

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Agency Case Files
- Internal Incident Management System Process and Reports
- 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) and First Aid for HHAs
- Licensure/Certification for Nursing
- Agency Policies and Procedures Manual
- Quality Assurance / Quality Improvement Plan

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

Attachment A

Provider Instructions for Completing the QMB Plan of Correction (POC) Process

Introduction:
After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued deficiencies and non-compliance.

Agencies must submit their Plan of Correction within ten (10) business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days may be referred to the DDSD Regional Office for purposes of contract management or the Internal Review Committee [IRC] for possible actions or sanctions).

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 505-273-1930 or email at MonicaE.Valdez@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 cited to prevent recurrence and information that ensures the regulation cited comes into and remains in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance (QA) Plan.

If a deficiency has already been corrected since the on-site survey, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

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

The Plan of Correction must address each deficiency cited in the Report of Findings unless otherwise noted with a "No Plan of Correction Required statement." The Plan of Correction must address the five (5) areas listed below:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect those individuals in similar situations.
3. What Quality Assurance measures will be put into place and what systemic changes made to ensure the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make certain solutions are sustained. The agency must develop a QA plan for ensuring correction is achieved and sustained. This QA plan must be implemented, and the corrective action is evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State.

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

- Details about how and when Individual Served, agency personnel and administrative and service delivery site files are audited by agency personnel to ensure they contain required documents;
- Information about how medication administration records are reviewed to verify they contain all required information before they are distributed to service sites, as they are being used, and after they are completed;
- Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management providers, how Individual Service Plans are reviewed to verify they meet requirements, how the timeliness of level of care (LOC) packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

Note: **Instruction or in-service of staff alone may not be a sufficient plan of correction.** This is a good first step toward correction, but additional steps must be taken to ensure the deficiency is corrected and will not recur.

Completion Dates

- The plan of correction must include a **completion date** (entered in the far right-hand column) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@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 Monica Valdez, POC Coordinator in any of the following ways:
    a. Electronically at MonicaE.Valdez@state.nm.us ***(preferred method)***
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108
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 documents containing HIPAA Protected Health Information (PHI) documents must be submitted

through S-Comm (Therap), Fax or Postal System, do not send PHI directly to NMDOH email accounts. If the documents do not contain protected Health information (PHI) then you may 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.

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

Attachment C

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

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

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Bureau Chief **within 10 business days** of receipt of the final Report of Findings **(*Note: No extensions are granted for the IRF)*.**
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: 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, Valerie V. Valdez at valerie.valdez@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/Region(s): **Harmony Home Health, Limited Liability Company - Metro and Northeast**
Program: Medically Fragile Waiver
Service(s): Home Health Aide (HHA), Private Duty Nursing (PDN), Respite HHA, Respite PDN
Survey Type: Routine
Survey Dates: **December 7 - 18, 2020**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Record Requirements:			
TAG # MF05 General Provider Requirements: Agency Case Files			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **V. PROVIDER AGENCY CASE FILE FOR THE WAIVER PARTICIPANT** All provider agencies are required to maintain at the administrative office a confidential case file for each person that includes all the following elements: a. Emergency contact information for the following individuals/entities that includes addresses and telephone numbers for each: i. Consumer ii. Primary caregiver iii. Family/relatives, guardians or conservators iv. Significant friends v. Physician vi. Case manager vii. Provider agencies viii. Pharmacy; b. Individual's health plan, if appropriate; c. Individual's current ISP; d. Progress notes and other service delivery documentation; e. A medical history which includes at least: demographic data; current and past medical	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 7 of 7 Individuals. **Review of the Agency's Individual case files revealed the following items were not found, incomplete, and/or not current:** **Emergency Contact Information:** • Did not contain complete Family/relatives, guardians or conservators' information (#5) • Did not contain complete Significant Friends Information (#1, 2, 3, 5, 7) • Did not contain complete Case Manager Information (#1, 2, 3, 4, 5, 6, 7) • Did not contain complete Provider Agencies information (#1, 2, 3, 4, 5, 7) • Did not contain complete Pharmacy Information (#7) **Medical History Information:** • Did not contain Psychiatric Diagnoses (#2, 3, 4, 5, 6, 7)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. **VI. DOCUMENTATION** A. Provider agencies must maintain all records necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to individuals who are currently receiving services. The provider agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, level of services, and length of service billed. B. The documentation of the billable time spent with an individual are kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record must contain at least the following information: a. date and start and end time of each service encounter or other billable service interval; b. description of what occurred during the encounter or service interval; and c. signature and title of staff providing the service verifying that the service and time are correct. C. All records pertaining to services provided to an individual must be maintained for at least six (6) years from the date of creation. D. 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 manifestation of signature, including the possibility for multiple parties to sign a document and have the order of application recognized and proven. In addition, 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. **NMAC 7.28.2.34 PATIENT/CLIENT RECORDS:** Each agency licensed pursuant to these regulations must maintain the original record for each patient/client receiving services. Patient/client records shall be made available for review upon request of the licensing authority. Every record must be accurate, legible, promptly completed and consistently organized. A patient/client record must meet the following criteria: A. Content of patient/client record: (1) Medically directed patient/client record must include: (a) past and current medical findings in accordance with accepted professional standard; (b) plan of care; (c) identifying information; (d) name of physician; (e) medications, diet, treatment/services, and activity orders; (f) signed and dated notes on the day service(s) provided;			

(g) copies of summary reports sent to the physician; (h) evidence of patient/client being informed of rights; (i) evidence of coordination of care provided by all personnel providing patient/client services; (j) discharge summary. (2) Non-medically directed patient/client records must include: (a) plan of care; (b) identifying information; (c) signed and dated notes on the day service(s) provided; (d) evidence of patient/client being informed of rights; (e) evidence of coordination of care of all personnel providing patient/client services; (f) evidence of discharge.			

TAG # MF05.1 General Provider Requirements: Agency Case Files – Documentation			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **GENERAL PROVIDER REQUIREMENTS** **V. PROVIDER AGENCY CASE FILE FOR THE WAIVER PARTICIPANT** All provider agencies are required to maintain at the administrative office a confidential case file for each person that includes all the following elements: a. Emergency contact information for the following individuals/entities that includes addresses and telephone numbers for each: i. Consumer ii. Primary caregiver iii. Family/relatives, guardians or conservators iv. Significant friends v. Physician vi. Case manager vii. Provider agencies viii. Pharmacy; b. Individual's health plan, if appropriate; c. Individual's current ISP; d. Progress notes and other service delivery documentation; e. A medical history which includes 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. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes.	Based on record review, the Agency did not maintain the complete required documentation necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to Individuals who are currently receiving services in the Agency's Case File for 4 of 7 Individuals. **Review of the Agency's Individual case files revealed the following items were not found incomplete and/or not current:** **Home Health Aide Progress Notes:** • **Individual #2** – Lacking description of what occurred during each encounter or service interval for September and October 2020. The Agency's form used for HHA Progress Notes used an electronic form to select either Done or Pt. Refused for Personal Cares, Elimination, Housekeeping, Activity, Meals, and Miscellaneous. (*Note: Per MFW standards / regulations, the record must contain a description of what occurred during the encounter or service interval*.) **Respite Home Health Aide Progress Notes:** • **Individual #3** – Lacking description of what occurred during each encounter or service interval for September and October 2020. The Agency's form used for Respite HHA Progress Notes used an electronic form to select either Done or Pt. Refused for Personal Cares, Elimination, Housekeeping, Activity, Meals, and Miscellaneous. (*Note: Per MFW standards / regulations, the record must contain a description of what occurred during the encounter or service interval*.)	**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?)*: →	

VI. DOCUMENTATION A. Provider agencies must maintain all records necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to individuals who are currently receiving services. The provider agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, level of services, and length of service billed. B. The documentation of the billable time spent with an individual are kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record must contain at least the following information: a. date and start and end time of each service encounter or other billable service interval; b. description of what occurred during the encounter or service interval; and c. signature and title of staff providing the service verifying that the service and time are correct. C. All records pertaining to services provided to an individual must be maintained for at least six (6) years from the date of creation. D. 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 manifestation of signature, including the possibility for multiple parties to sign a document and have the order of application recognized and proven. In addition, 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,	• **Individual #6** – Lacking description of what occurred during each encounter or service interval for September and October 2020. The Agency's form used for Respite HHA Progress Notes used an electronic form to select either Done or Pt. Refused for Personal Cares, Elimination, Housekeeping, Activity, Meals, and Miscellaneous. (*Note: Per MFW standards / regulations, the record must contain a description of what occurred during the encounter or service interval*.) • **Individual #7** – Lacking description of what occurred during each encounter or service interval for September and October 2020. The Agency's form used for Respite HHA Progress Notes used an electronic form to select either Done or Pt. Refused for Personal Cares, Elimination, Housekeeping, Activity, Meals, and Miscellaneous. (*Note: Per MFW standards / regulations, the record must contain a description of what occurred during the encounter or service interval*.)		

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. **<u>HOME HEALTH AIDE (HHA):</u> 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-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 through the children's EPSDT program. E. The Medicaid benefit is the payer of last resort. Payment 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 services. G. The HH Agency must follow all current billing requirements by the HSD and the DOH for HHA services. H. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC. I. Providers of service have the responsibility to review and assure that the information on 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. J. 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 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 without agency approval; 6. Pick up and/or delivery of commodities; and 7. Other non-Medicaid reimbursable activities. **RESPITE STANDARDS:** **II. IN-HOME RESPITE** B. Agency Provider Requirement 1. The agency is responsible to ensure that the direct support professionals (RN, LPN, and			

HHA) meet all applicable MFW, State and Federal requirements for PDN and HHA. 2. The agency will follow the MFW PDN and HHA Standards. 3. Respite services must be provided by qualified personnel as delineated in the agency's licensure requirements and follow the MFW Standards and the MFW Provider Agreement. 4. Advance notice to the CM is required. This includes a timeline from the person/person's representative. 5. A log of respite hours used must be established and maintained. 6. The CM must complete and approve required paperwork for the agency's respite services prior to implementation. 7. All services provided during respite must be documented following the documentation standards by the MFW, State, Federal and agency requirements. 8. The agency personnel must be culturally sensitive to the needs and preferences of person and members of their household. Arrangement of written or spoken communication in another language may need to be considered. **NMAC 8.314.3.17 Reimbursement:** Waiver service providers must submit claims for reimbursement to MAD's fiscal contractor for processing. Claims must be filed per the billing instructions in the Medicaid policy manual. Providers must follow all Medicaid billing instructions. See Section 8.302.2 NMAC. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to providers of Medicaid waiver services is made at a predetermined reimbursement rate. [8.314.3.17 NMAC - Rp, 8 .314.3.17 NMAC, 3/1/2018]			

NMAC 7.28.2.34 PATIENT/CLIENT RECORDS: Each agency licensed pursuant to these regulations must maintain the original record for each patient/client receiving services. Patient/client records shall be made available for review upon request of the licensing authority. Every record must be accurate, legible, promptly completed and consistently organized. A patient/client record must meet the following criteria: A. Content of patient/client record: (1) Medically directed patient/client record must include: (a) past and current medical findings in accordance with accepted professional standard; (b) plan of care; (c) identifying information; (d) name of physician; (e) medications, diet, treatment/services, and activity orders; (f) signed and dated notes on the day service(s) provided; (g) copies of summary reports sent to the physician; (h) evidence of patient/client being informed of rights; (i) evidence of coordination of care provided by all personnel providing patient/client services; (j) discharge summary. (2) Non-medically directed patient/client records must include: (a) plan of care; (b) identifying information; (c) signed and dated notes on the day service(s) provided; (d) evidence of patient/client being informed of rights; (e) evidence of coordination of care of all personnel providing patient/client services; (f) evidence of discharge.			

TAG # MF22 Private Duty Nursing: Scope of Services – Plans / Assessments			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **PRIVATE DUTY NURSING** **I. SCOPE OF SERVICE** A. Initiation of PDN Services: When a PDN service is identified as a recommended service, the CM will provide the participant/participant's representative with a Secondary Freedom of Choice (SFOC) form from which the participant/participant's representative selects a Home Health (HH) Agency. Working with the HH Agency and participant/participant's representative, the CM will facilitate the selection of a RN or LPN employed by the chosen agency. The identified agency will obtain a referral/prescription from the Primary Care Provider (PCP) for PDN services. This referral/prescription will be in accordance with Federal and State regulations for licensed HH Agencies. This must be obtained before initiation of treatment. A copy of the written referral will be maintained in the participant's file at the HH Agency. The CM is responsible for including recommended units/hours of services on the MAD 046 form. It is the responsibility of the participant/participant's 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:	Based on record review and interview, the Agency did not ensure that the HH Agency's RN Supervisor or RN designee nursing scope of services documentation was complete for 6 of 7 Individuals. **Review of the Agency's Individual case files revealed the following items were not found, incomplete, and/or not current:** **CMS-485 not reviewed by RN Supervisor or RN designee at least every 60 days as required for the following:** • **Individual #7** – No evidence of RN Supervisor or RN designee review of CMS-485 for: 4/2020 for certification period covering 4/17/2020 – 6/17/2020. **Medication Profiles not reviewed by RN Supervisor or RN designee at least every 60 days as required for the following:** • **Individual #1** – No evidence that Medication Profiles were reviewed by the RN Supervisor or RN designee for: 7/2020 and 9/2020. • **Individual #3** – No evidence that Medication Profiles were reviewed by the RN Supervisor or RN designee for: 12/2019, 2/2020, 4/2020, 6/2020, 8/2020 and 10/2020. • **Individual #4** – No evidence that Medication Profiles were reviewed by the RN Supervisor or RN designee for: 2/2020, 04/2020, 06/2020, 8/2020 and 10/2020. • **Individual #5** – No evidence that Medication Profiles were reviewed by the RN Supervisor	**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?)*: →	

1. The private duty nurse provides nursing services in accordance with the New Mexico Nursing Practice Act, Chapter 61, and Article 3 NMSA 1978. 2. The private duty nurse develops, implements, evaluates and coordinates the medically fragile 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's home. 3. The private duty nurse provides the participant, caregiver, and family all training and education pertinent to the treatment plan and equipment used by the participant. 4. The private duty nurse must meet the documentation requirements of the MFW, Federal and State HH Agency licensing regulations and all policies and procedures of the HH Agency where the nurse is employed. All documentation must include dates and types of treatments performed; as well as person's response to treatment and progress towards all goals. 5. The private duty nurse must 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 implements 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 administers 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,	or RN designee for: 12/2019, 2/2020, 04/2020, 06/2020, 8/2020 and 10/2020. • **Individual #6** – No evidence that Medication Profiles were reviewed by the RN Supervisor or RN designee for: 2/2020, 04/2020, 06/2020, 8/2020 and 10/2020. **When Agency Personnel was asked if there was a copy of the Nursing Plan of Care in the Individual's home, the following was reported:** • RN #222 stated, "No plan in home." (Individual #1)		

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; and g. Contraindications 11. The private duty nurse must follow the HH Agency's policy and procedure for management of medication errors. 12. The private duty nurse providing direct care to a medically fragile 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. 13. The private duty nurse develops and maintains skills to safely manage all devices and equipment needed in providing care for the participant. 14. The private duty nurse monitors all equipment for safe functioning and facilitates 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. Obtaining pertinent medical history; b. Assisting in the development and implementation of bowel and bladder regimens and monitor such regimens and modify as needed. This includes removal of fecal impactions and bowel and/or bladder training, urinary catheter and supra-public catheter care; c. Assisting with the development, implementation, modification, and monitoring of nutritional needs via feeding tubes and orally per Physician/Healthcare Practitioner order and within the nursing scope of practice; d. Providing ostomy care per Physician/Healthcare Practitioner order; e. Monitoring respiratory status and treatments including the participant's response to therapy; f. Providing rehabilitative nursing; g. Collecting specimens and obtaining cultures per Physician/Healthcare Practitioner order; h. Providing routine assessment, implementation, modification, and monitoring of skin condition and wounds; i. Providing routine assessment, implementation, modification, and monitoring of Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL); j. Monitoring vital signs per Physician/Healthcare Practitioner orders or per HH Agency policy. 17. The private duty nurse must consult and collaborate with the participant's PCP, specialists, 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. This collaboration with team members will include, but will not be limited to, the following: a. Analyzing and interpreting the person's needs on the basis of medical history, pertinent			

precautions, limitations, and evaluative findings; b. Identifying short and long-terms 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 plan of care is based on the Physician/Healthcare Practitioner treatment plan and the medically fragile participant's and 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 must review Physician/Healthcare Practitioner orders for 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 coordinates 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. 22. The private duty nurse may ride in the vehicle with the person for the purpose of oversight, support, or monitoring during transportation. The private duty nurse may not operate the vehicle for the purpose of transporting the participant. **RESPITE STANDARDS** **II. IN-HOME RESPITE** B. Agency Provider Requirement 1. The agency is responsible to ensure that the direct support professionals (RN, LPN, and HHA) meet all applicable MFW, State and Federal requirements for PDN and HHA.			

2. The agency will follow the MFW PDN and HHA Standards. 3. Respite services must be provided by qualified personnel as delineated in the agency's licensure requirements and follow the MFW Standards and the MFW Provider Agreement. 4. Advance notice to the CM is required. This includes a timeline from the person/person's representative. 5. A log of respite hours used must be established and maintained. 6. The CM must complete and approve required paperwork for the agency's respite services prior to implementation. 7. All services provided during respite must be documented following the documentation standards by the MFW, State, Federal and agency requirements. 8. The agency personnel must be culturally sensitive to the needs and preferences of person and members of their household. Arrangement of written or spoken communication in another language may need to be considered.			

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 July 1, 2019 **PRIVATE DUTY NURSING:** **I. SCOPE OF SERVICE** **D. Attendance at the IDT Meeting:** 1. The HH Agency's RN supervisor is the HH Agency's representative at the IDT meeting. A RN alternative may represent the agency at the IDT meeting if the supervising nurse is unable to attend in person or 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 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 at 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. **RESPITE STANDARDS**	Based on record review, the Agency did not ensure that the HH Agency's RN Supervisor or RN designee nursing scope of services documentation was complete for 5 of 7 Individuals. **Review of the Agency's Individual case files revealed the following items were not found, incomplete, and/or not current:** • **Individual #1** – Documentation received related to the coordination of any changes to strategies, nursing care plans, goals, and objectives as a result of the IDT meeting dated 5/27/2020 was missing the "time", as required by standard. • **Individual #2** – Documentation received related to the coordination of any changes to strategies, nursing care plans, goals, and objectives as a result of the IDT meeting dated 9/8/2020 was missing the "time", as required by standard. • **Individual #4** – Documentation received related to the coordination of any changes to strategies, nursing care plans, goals, and objectives as a result of the IDT meeting dated 9/18/2020 was missing the "time", as required by standard. • **Individual #5** – Documentation received related to the coordination of any changes to strategies, nursing care plans, goals, and objectives as a result of the IDT meeting dated 10/20/2020 was missing the "time", as required by standard.	**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?)*: →	

II. IN-HOME RESPITE B. Agency Provider Requirement 1. The agency is responsible to ensure that the direct support professionals (RN, LPN, and HHA) meet all applicable MFW, State and Federal requirements for PDN and HHA. 2. The agency will follow the MFW PDN and HHA Standards. 3. Respite services must be provided by qualified personnel as delineated in the agency's licensure requirements and follow the MFW Standards and the MFW Provider Agreement. 4. Advance notice to the CM is required. This includes a timeline from the person/person's representative. 5. A log of respite hours used must be established and maintained. 6. The CM must complete and approve required paperwork for the agency's respite services prior to implementation. 7. All services provided during respite must be documented following the documentation standards by the MFW, State, Federal and agency requirements. 8. The agency personnel must be culturally sensitive to the needs and preferences of person and members of their household. Arrangement of written or spoken communication in another language may need to be considered.	• **Individual #6** – Documentation received related to the coordination of any changes to strategies, nursing care plans, goals, and objectives as a result of the IDT meeting dated 1/6/2020 was missing the "time", as required by standard.		

TAG # MF23 Private Duty Nursing: Agency/Individual Requirements			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **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 Standards, 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 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 Supervisors(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 participant, participant representative and households. Arrangement of written or spoken communication in another language must be considered.	Based on record review, the Agency did not ensure documentation of monthly contact between the HH Agency and Case Manager which reflects the discussion and review of services and ongoing coordination of care for 6 of 7 Individuals. **Review of the Agency's Individual case files revealed no evidence of monthly contact between the HH Agency and Case Manager for the following:** • **Individual #1** – Not found for 6/2020 and 9/2020. • **Individual #2** – Not found for 12/2019 – 1/2020. • **Individual #3** – Not found for 12/2019 – 5/2020 and 9/2020. • **Individual #5** – Not found for 12/2019, 3/2020 – 8/2020 and 11/2020. • **Individual #6** – Not found for 12/2019. • **Individual #7** – Not found for 11/2019 – 8/2020.	**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 person'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 must 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 trains 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.			

TAG # MF27.1 HHA and PDN: Agency/Individual Requirements – RN Supervision			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>HOME HEALTH AIDE (HHA)</u>** **II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS** 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 NMAC 28.2., 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 NMAC 28.2., 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. 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.	Based on record review and interview, the Agency did not ensure complete documentation that the Home Health Aide and/or Private Duty Nurse were supervised by the Agency's RN Supervisor as required for 7 of 7 Individuals. **Review of the Agency's Individual case files revealed RN supervisory visits with the Home Health Aide were not found and/or did not contain all required elements for the following:** • **Individual #2** – The following elements were not found for; 11/18/2019, 12/23/2019, 2/24/2020, 4/23/2020, 6/23/2020, 8/11/2020 and 10/19/2020. ➢ Participant's Status; ➢ Contact with Family Members; ➢ Review of HHA plan of care with appropriate modification annually and as needed. • **Individual #3** – The following elements were not found for; 11/6/2019, 1/22/2020, 3/4/2020, 5/15/2020, 6/19/2020, 7/22/2020, 8/18/2020, 10/12/2020 and 11/10/2020. ➢ Participant's Status; ➢ Contact with Family Members; ➢ Review of HHA plan of care with appropriate modification annually and as needed. • **Individual #6** – The following elements were not found for; 11/18/2019, 1/17/2020, 3/16/2020, 5/13/2020, 7/10/2020, 9/17/2020 and 11/5/2020. ➢ Participant's Status; ➢ Review of HHA plan of care with	**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 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 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 must 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 the	appropriate modification annually and as needed. The following element was not found for; 5/13/2020, 7/10/2020, 9/17/2020 and 11/5/2020. ➢ Contact with Family Members • **Individual #7** – The following elements were not found for; 11/18/2019, 1/21/2020, 3/25/2020, 5/8/2020, 7/21/2020, 8/14/2020, 9/11/2020, 10/22/2020 and 11/17/2020. ➢ Participant's Status; ➢ Review of HHA plan of care with appropriate modification annually and as needed. The following element was not found for; 3/25/2020, 5/8/2020, 7/21/2020, 8/14/2020, 9/11/2020, 10/22/2020 and 11/17/2020. ➢ Contact with Family Members **Review of the Agency's Individual case files revealed RN supervisory visits with the Private Duty Nurse were not found for the following:** • **Individual #1** – Not found for 6/2020, 8/2020, and 10/2020. • **Individual #4** – Not found for 8/2020, and 11/2020. • **Individual #5** – Not found for 11/2019, 1/2020, 3/2020, 5/2020, 7/2020, 9/2020 and 11/2020. • **Individual #6** – Not found for 11/2019, 1/2020, 3/2020, 5/2020, 7/2020, 9/2020 and 11/2020.		

discussion and review of services and ongoing coordination of care. 7. The HH Agency supervising RN, direct care RN and LPN trains 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. **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 Standards, 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 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 Supervisors(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN, and Home Health Aide (HHA).	**When the Agency's RN Supervisor was asked how often did you conduct face-to-face supervisory visits with the staff you supervise, the following was reported:** • #228 stated, "…has not been routine for nurses…60 days…". (*Note: Per MFW Standards; The HH Agency must 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.)*		

5. The HH Agency staff will be culturally sensitive to the needs and preferences of participant, participant representative and households. Arrangement of written or spoken communication in another language must 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 person'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 must 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 trains 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 7.28.2.29 SUPERVISION OF SECONDARY AND NONLICENSED PERSONNEL:** **A. Licensed practical nurses:** Services and care provided by a licensed practical nurse will be furnished under the supervision of a registered nurse who has a minimum of one			

year home health experience or a minimum of two years nursing experience. Such supervision will include, at a minimum: **(1)** Identify appropriate tasks to be performed by the licensed practical nurse. **(2)** Conduct and document a supervisory visit to at least one patient/client residence at least every 60 days, or more often as indicated. **D. Home health aides:** Services and care provided by a home health aide will be furnished under the supervision of an appropriately licensed professional, such as, registered nurse, physical therapist, occupational therapist, or a speech language pathologist with a minimum of one year experience. Such supervision will include, at a minimum: **(1)** Preparation of written patient/client instructions which identify appropriate tasks to be performed by the home health aide. **(2)** Conduct and document a supervisory visit to the patient/client residence at least every 62 days or as often as the condition of the patient/client requires. Note: Patient/clients who have multiple home health aides require only one supervisory visit. This home health aide need not be present in the patient/client's residence at the time of the supervisory visit.			

TAG # MF28 Home Health Aide: Administrative Requirements – Emergency Backup Plan			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>HOME HEALTH AIDE (HHA)</u>** **III. ADMINISTRATIVE REQUIREMENTS** The administrative requirements are directed at the HH Agency, Rural Health Clinic or Licensed or Certified Federally Qualified Health Center. E. A HH Agency may consider hiring a participant's family member to provide HHA services if no other staff are available. The intent of the HHA service is to provide support to the family, and extended family should not circumvent the natural family support system. F. A participant's spouse or parent, if the participant is a minor child, cannot be considered as a HHA. G. The HHA is not a primary care giver, therefore when the HHA is on duty; there must be an approved primary caregiver available in person. The participant and/or representative and agency have the responsibility to assure there is a primary caretaker available in person. The primary caregiver or a responsible adult must be available on the property where the participant is currently located and within audible range of the participant and HHA. H. All designated primary caretakers' names and phone numbers must be written in the backup plan and agreed upon by the agency and / representative. The designated approved back up primary caregiver will not be reimbursed by the MFW/DDSD. I. An emergency back up plan for medical needs and staffing must be developed, written and agreed upon by the HH Agency and	Based on record review, the Agency did not ensure the documentation of the Emergency Backup Plan for 4 of 7 Individuals. **Review of the Agency's Individual case files revealed the Emergency Backup Plan was not current:** • **Individual #2** – Emergency Backup Plan found was dated 10/7/2019, no evidence found that it was reviewed at least annually. • **Individual #3** – Emergency Backup Plan found was dated 1/16/2019, no evidence found that it was reviewed at least annually. • **Individual #6** – Emergency Backup Plan found was dated 9/20/2019, no evidence found that it was reviewed at least annually. **Review of the Agency's Individual case files revealed the Emergency Backup Plan was incomplete:** • **Individual #2** – Emergency Backup Plan found dated 10/7/2019, was missing the following information; ➢ Medical Needs and; ➢ Staffing • **Individual #7** – Emergency Backup Plan found dated 2/28/2020, was missing the following information; ➢ Medical Needs and; ➢ Staffing	**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?)*: →	

participant/participant's representative. This emergency back up plan will be available in participant's home. This plan will be modified when medical conditions warrant and will be reviewed at least annually. **RESPITE STANDARDS** **II. IN-HOME RESPITE** **A. Scope of Service:** 1. In-home respite provider must be a licensed HH Agency, licensed or certified Federally Qualified Health Center, or a Licensed Rural Health Clinic and a Medically Fragile Waiver Provider. 2. RN and LPN are the only category who can provide twenty-four (24) continuous hours of approved in-home respite services. RNs and LPNs must meet and comply with all MFW Private Duty Nursing (PDN) Standards. 3. The HH Agency must request and receive an agreement between the CM, HH Agency and participant/participant's representative to deliver in-home respite services by a HHA. This must be identified in the ISP. a. The participant/participant's representative is required to submit a request in writing to the CM. b. The participant/participant's representative, CM and HH Agency will meet to develop the HHA respite plan. c. The HHA plan for providing respite services must include but not limited to: i. Which approved primary care givers will be available to the HHA; ii. Which approved primary care givers will be providing services which are outside the HHA scope of practice; iii. Specific hours respite services will be provided. The HHA will not provide 24 continuous hours of respite;			

d. The services provided must be within the scope of the HHA skills as identified in the MFW HHA standards; e. A HH Agency RN or LPN must be available for back-up emergency services. 4. A list of approved primary care givers will be maintained in the home in a central location. This list will be signed by the participant/participant's representative. 5. It may be necessary to coordinate in-home respite services with more than one agency to provide 24-hour coverage by RN and/or LPN. 6. In-home respite services include medical and non-medical care. 7. An emergency back-up plan must be in place prior to the initiation of the respite service. **B. Agency Provider Requirement** 1. The agency is responsible to ensure that the direct support professionals (RN, LPN, and HHA) meet all applicable MFW, State and Federal requirements for PDN and HHA. 2. The agency will follow the MFW PDN and HHA Standards.			

TAG # MF1A28.2 Incident Management System / ANE Acknowledgement – Individual/Family/Guardian			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **I. PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. C. All providers must be currently enrolled as a MFW provider through the Developmental Disabilities Supports Division (DDSD) Provider Enrollment Unit process: a. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures. b. All provider agencies that enter a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies and standards. c. Reference: http://dhi.health.state.nm.us/ D. All agencies must follow all applicable DDSD Policies and Procedures. **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** A. Duty to report: **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers. **(2)** All community-based service	Based on record review and interviews, the Agency did not provide documentation which indicates the Incident Management System / ANE Policy and Procedural information had been acknowledged by the Individual/Family and/or their legal guardians for reporting Abuse, Neglect and Exploitation for 7 of 7 Individuals. **Review of Agency's Individual case files revealed the following items were not found, incomplete and/or not current:** **Incident Management System / ANE Policy and Procedural acknowledgement signed statement:** • Not current for Individuals #1, 2, 3, 4, 5, 6, 7 *(Note: The Harmony HH Admission Consent Form in the 1st paragraph does not reference DHI/IMB to be contacted for reporting Abuse, Neglect and Exploitation. The Admission Consent Form indicates in the 1st paragraph; "I acknowledge receipt and explanation of the agency's policy for reporting abuse, neglect and exploitation and the contact information and process for reporting abuse, neglect and exploitation to NM Adult Protective Services and Health Facility Licensing and Certification Bureau.")* **When the Individual/Family member was asked if they had received training on Abuse, Neglect and Exploitation and how to report, the following was reported:** • Individual #5 – Family member stated, "No."	**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?)*: →	

providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:** **(1) Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242. **(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:** In			

addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form. **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **E. Consumer and guardian orientation packet:** Consumers, family members, and legal guardians shall be made aware of and have available immediate access to the community-based service provider incident reporting processes. The community-based service provider shall provide consumers, family members, or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect, exploitation, suspicious injury, or death. The community-based service provider shall include a signed statement indicating the date, time,			

and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member, or legal guardian shall sign this at the time of orientation.			

TAG # MF129 Complaints and Grievances Acknowledgement – Individual/Family/Guardian			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **I. PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. **<u>NMAC 7.26.3.6</u> OBJECTIVE:** A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **<u>NMAC 7.26.3.13</u> Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **<u>NMAC 7.26.4.12</u> Complaint Procedure Available:**	Based on record review, the Agency did not provide documentation which indicates the acknowledgement of the Complaint and Grievance Procedure had been made available to Individuals/Family and/or their legal guardians for 7 of 7 Individuals. **Review of Agency's Individual case files revealed the following items were not found, incomplete and/or not current:** **Complaint and Grievance Policy and Procedure Acknowledgement:** • No Agency Complaints and Grievance acknowledgement found for Individuals (#1, 2, 3, 4, 5, 6, 7)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

A. The complaint process (Section 13 [now 7.26.4.13 NMAC] of this regulation) is available to resolve complaints alleging that a service provider, its employee, or a person acting under contract with the service provider has violated rights of the client set forth in the federal or state constitutions, statutes or applicable department regulations or policies and such violation adversely affects the client. The administrative appeal process Section 14 [now 7.26.4.14 NMAC] of this regulation) is available, however, only as to alleged violations of rights set forth in the federal and state constitutions, statutes and department regulations and policies designated “Client's Rights.” **B.** The complaint procedure shall be available to clients or their legal guardians. The client or the legal guardian has the right to a legal representative or advocate of his or her choice at no expense to the department. **NMAC 7.26.4.13 COMPLAINT PROCESS:** **A. (2).** The service provider’s complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider’s complaint or grievance procedure. **NMAC 7.28.2.40 COMPLAINTS:** The home health agency must investigate complaints made by a patient/client, caregiver, or guardian regarding treatment or care, or regarding the lack of respect for the patient/client’s property and must document both the existence of the complaint and the resolution of the complaint. The agency’s investigation of a complaint(s) must be initiated within three working days. [7.28.2.40 NMAC - Rp 7 NMAC 28.2.40, 11/10/2020]			

<u>NMAC 8.314.3.20</u> GRIEVANCE SYSTEM: An eligible recipient has the opportunity to register a grievance or complaint concerning the MFW program. An eligible recipient may register complaints with DOH via e-mail, mail or phone. Complaints will be referred to the appropriate DOH division or as appropriate referred to MAD for resolution. The filing of a complaint or grievance does not preclude an eligible recipient from pursuing a HSD administrative hearing. The eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for requesting a HSD administrative hearing. [8.314.3.20 NMAC - N, 3/1/2018]			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Personnel Requirements:			
TAG # MF 1A25 **Criminal Caregiver History Screening**			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **I.PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. **<u>NMAC 7.1.9.8</u> CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:** **A. General:** The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA	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 2 of 15 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** • #210 – Date of hire 11/4/2020. • #214 – Date of hire 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?)*: →	

1978 (Amended) of the act, a care provider's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider] to impose appropriate administrative sanctions and penalties. **B. Exception:** A caregiver or hospital caregiver applying for employment or contracting services with a care provider within twelve (12) months of the caregiver's or hospital caregiver's most recent nationwide criminal history screening which list no disqualifying convictions shall only apply for a statewide criminal history screening upon offer of employment or at the time of entering into a contractual relationship with the care provider. At the discretion of the care provider a nationwide criminal history screening, additional to the required statewide criminal history screening, may be requested. **C. Conditional Employment:** Applicants, caregivers, and hospital caregivers who have submitted all completed documents and paid all applicable fees for a nationwide and statewide criminal history screening may be deemed to have conditional supervised employment pending receipt of written notice given by the department as to whether the applicant, caregiver or hospital caregiver has a disqualifying conviction. **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **G. Maintenance of Records:** Care providers shall maintain documentation relating to all			

employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. **NMAC 7.1.9.9** **A. Prohibition on Employment:** Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11** **DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances;			

C. kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection. [7.1.9.9 NMAC - Rp, 7.1.9.9 NMAC, 01/01/06]			

TAG # MF 1A26 Consolidated On-line Registry / Employee Abuse Registry			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **GENERAL PROVIDER REQUIREMENTS** **I. PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. **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.	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 8 of 15 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:** • #210 – Date of hire 11/4/2020. • #212 – Date of hire 12/3/2019. • #214 – Date of hire 7/26/2018. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** • #201 – Date of hire 8/28/2018, completed 8/31/2018. • #204 – Date of hire 1/15/2019, completed 1/18/2019. • #207 – Date of hire 12/3/2019, completed 12/6/2019. • #208 – Date of hire 11/6/2018, completed 3/12/2019. • #213 – Date of hire 12/26/2018, completed 3/12/2019.	**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?)*: →	

B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to 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 Management System – Agency Personnel Training			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **I. PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. C. All providers must be currently enrolled as a MFW provider through the Developmental Disabilities Supports Division (DDSD) Provider Enrollment Unit process: a. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures. b. All provider agencies that enter a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies and standards. c. Reference: http://dhi.health.state.nm.us/ D. All agencies must follow all applicable DDSD Policies and Procedures. **<u>NMAC 7.1.14.8</u> INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** A. Duty to report: **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers.	Based on record review and interview, the Agency did not ensure Incident Management ANE Training for 10 of 29 Agency Personnel. **The following was found with regards to the annual NM DOH Incident Management ANE training:** **Home Health Aide:** ***Not Found:*** • #204, 211 ***Not Current:*** • #200 **Private Duty Nursing:** ***Not Found:*** • #216, 218, 220, 222 ***Not Current*:** • #217, 227 **When Agency Personnel were asked; What State Agency do you report to if you suspect any Abuse, Neglect and Exploitation, the following was reported:** • PDN #218 stated, "…not sure…given paperwork…" Staff was not able to identify the State Agency as Division of Health Improvement. • PDN #222 stated, "Health and Human Services in Santa Fe. Would call Anitha." 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?)*: →	

(2) All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:** **(1) Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242. **(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:** In	**When Agency Personnel were asked to give examples of Abuse, Neglect and Exploitation, the following was reported:** • HHA #208 stated, "…don't care for child..." for Exploitation. • PDN #218 stated, "…intentionally not giving care..." for Abuse. • PDN #222 stated, "…not known..." for Exploitation.		

addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form. **(3) Limited provider investigation:** No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation. **(4) Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall: **(a)** develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable; **(b)** be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and 4			

(c) provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted by faxing it to the division at 1-800-584-6057. **(5) Evidence preservation:** The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident. **(6) Legal guardian or parental notification:** The responsible community-based service provider shall ensure that the consumer's legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division's investigative representative. **(7) Case manager or consultant notification by community-based service providers:** The responsible community-based service provider shall notify the consumer's case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation has been reported to the division. Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant.			

(8) Non-responsible reporter: Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation. **D. Incident policies:** All community-based service providers shall maintain policies and procedures which describe the community-based service provider's immediate response, including development of an immediate action and safety plan acceptable to the division where appropriate, to all allegations of incidents involving abuse, neglect, or exploitation, suspicious injury as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC. **E. Retaliation:** Any person, including but not limited to an employee, volunteer, consultant, contractor, consumer, or their family members, guardian, and another provider who, without false intent, reports an incident or makes an allegation of abuse, neglect, or exploitation shall be free of any form of retaliation such as termination of contract or employment, nor may they be disciplined or discriminated against in any manner including, but not limited to, demotion, shift change, pay cuts, reduction in hours, room change, service reduction, or in any other manner without justifiable reason. **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be			

competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **B. Training curriculum:** Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer. **C. Incident management system training curriculum requirements:** **(1)** The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to: **(a)** an overview of the potential risk of abuse, neglect, or exploitation; **(b)** informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths; **(d)** specific instructions on how to respond to abuse, neglect, or exploitation;			

(e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury. **(2)** All current employees and volunteers shall receive training within 90 days of the effective date of this rule. **(3)** All new employees and volunteers shall receive training prior to providing services to consumers. **D. Training documentation:** All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule.			

TAG # MF24 Private Duty Nursing: Agency/Individual Provider Requirements			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **GENERAL PROVIDER REQUIREMENTS** **I. PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. **PRIVATE DUTY NURSING** **II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS** A. PDN services must be furnished through a licensed HH Agency, licensed Rural Health Clinic, or certified Federally Qualified Health Center. All Federal/State requirements for each are applicable when providing services for the MFW participant. B. All private duty nurses (RN or LPN) working as employees of the HH Agency must meet all the requirements of the MFW Service Standards, New Mexico Board of Nursing and HH Agency policies and procedures. **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	Based on record review, the Agency did not maintain Agency Personnel file documentation for 11 of 14 agency personnel. **Review of the Private Duty Nursing Agency Personnel files found no evidence of preferred nursing experience in the area of developmental disabilities and/or medically fragile conditions or evidence of completing an approved internship or similar program, as approved by the MFW Manager and Human Services Department (HSD) representative for following:** • #215 – Date of hire 7/8/2011 • #216 – Date of hire 12/1/2015 • #217 – Date of hire 9/11/2018 • #218 – Date of hire 8/16/2016 • #220 – Date of hire 2/17/2015 • #222 – Date of hire 7/23/2013 • #223 – Date of hire 7/30/2013 • #225 – Date of hire 9/5/2017 • #226 – Date of hire 7/23/2013 • #227 – Date of hire 3/8/2016 • #228 – Date of hire 5/14/2013	**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?)*: →	

Standards, 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 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 Supervisors(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN, and Home Health Aide (HHA). **RESPITE STANDARDS** **II. IN-HOME RESPITE** A. Scope of Service: 1. In-home respite provider must be a licensed HH Agency, licensed or certified Federally Qualified Health Center, or a Licensed Rural Health Clinic and a Medically Fragile Waiver Provider. 2. RN and LPN are the only category who can provide twenty-four (24) continuous hours of approved in-home respite services. RNs and LPNs must meet and comply with all MFW Private Duty Nursing (PDN) Standards. B. Agency Provider Requirement 1. The agency is responsible to ensure that the direct support professionals (RN, LPN, and HHA) meet all applicable MFW, State and Federal requirements for PDN and HHA. 2. The agency will follow the MFW PDN and HHA Standards. 3. Respite services must be provided by qualified personnel as delineated in the agency's licensure requirements and follow the MFW Standards and the MFW Provider Agreement.			

NMAC 7.28.2.23 REQUIREMENTS FOR LICENSURE OF PROFESSIONALS: Any health professional employed or contracted by the home health agency, such as, but not limited to, physicians, physician's assistants, nurse practitioners, physical or occupational therapists, speech language pathologists, registered professional nurses, licensed practical nurses, licensed or certified social workers, physical therapy assistants or certified occupational therapy assistants, must have a current license, registration or certification from the state of New Mexico. Proof of licensure must be maintained on file by the agency. [7.28.2.23 NMAC - Rp 7 NMAC 28.2.23, 11/10/2020]			

TAG # MF26 Pre-employment – Tuberculosis Testing			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **GENERAL PROVIDER REQUIREMENTS** **I. PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. **NMAC 7.28.2.37.E. STAFF RECORDS:** Each agency licensed pursuant to these regulations must maintain a complete record on file for each staff member and for all volunteers with in-home contact or working more than half-time. Staff records shall be made available for review upon request of the licensing authority within four hours. Staff records must contain at least the following: **A.** name; **B.** address; **C.** position for which employed; **D.** date of employment; **E.** 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; **F.** a copy or proof of the current license, registration or certificate for each staff member for whom a license, registration, or certification is required by the state of New Mexico. [7.28.2.37 NMAC - Rp 7 NMAC 28.2.37, 11/10/2020]	Based on record review, the Agency did not maintain documentation for all staff having contact with patient/clients stating that the employee is free from tuberculosis for 2 of 29 agency personnel. **Review of the Agency Personnel files revealed no evidence of Tuberculosis Testing was done upon hire:** • HHA #214 – Date of hire 7/26/2018. **Review of the Agency Personnel files revealed Tuberculosis Testing was not completed upon hiring:** • HHA #213 – Date of hire 12/26/2018, was completed on 1/17/2019.	**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 Home Health Aide: Agency/Individual Provider Requirements – Ongoing Training			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **I. PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. **<u>HOME HEALTH AIDE (HHA)</u>** **II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS** 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 NMAC 28.2., 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 NMAC 28.2., 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	Based on record review, the Agency did not ensure Orientation and Training requirements were met for 14 of 15 Direct Support Personnel. **Review of HHA Personnel training records found no evidence of the following required DOH trainings and certification being completed**: **12-Hours of Annual In-service Training:** • Not Found (#202, 206, 214) **CPR Certification / Training:** • Not Found (#200, 213) **First Aid Certification / Training:** • Not Found (#200, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214)	**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?)*: →	

the employing HH Agency's written and practical competency standards before providing direct care services. Documentation will be maintained in personnel file. 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. **III. ADMINISTRATIVE REQUIREMENTS** The administrative requirements are directed at the HH Agency, Rural Health Clinic or Licensed or Certified Federally Qualified Health Center. A. The HH Agency will maintain licensure as a HH Agency, Rural Health Clinic or Federally Qualified Health Center, or maintain certification as a Federally Qualified Health Center. B. The HH Agency will assure that HHA services are delivered by an employee meeting the educational, experiential and training requirements as specified in the Federal 42 CFT 484.36 or State 7 NMAC 28.2. C. Copies of CNA certificates must be requested by the employer and maintained in the personnel file of the HHA. D. The HH Agency will implement HHA care activities/plan of care per the participant's ISP identified strengths, concerns, priorities and outcomes. E. A HH Agency may consider hiring a participant's family member to provide HHA services if no other staff are available. The intent of the HHA service is to provide support			

to the family, and extended family should not circumvent the natural family support system. F. A participant's spouse or parent, if the participant is a minor child, cannot be considered as a HHA. G. The HHA is not a primary care giver, therefore when the HHA is on duty; there must be an approved primary caregiver available in person. The participant and/or representative and agency have the responsibility to assure there is a primary caretaker available in person. The primary caregiver or a responsible adult must be available on the property where the participant is currently located and within audible range of the participant and HHA. **RESPITE STANDARDS** **II. IN-HOME RESPITE** A. Scope of Service: 1. In-home respite provider must be a licensed HH Agency, licensed or certified Federally Qualified Health Center, or a Licensed Rural Health Clinic and a Medically Fragile Waiver Provider. 2. RN and LPN are the only category who can provide twenty-four (24) continuous hours of approved in-home respite services. RNs and LPNs must meet and comply with all MFW Private Duty Nursing (PDN) Standards. 3. The HH Agency must request and receive an agreement between the CM, HH Agency and participant/participant's representative to deliver in-home respite services by a HHA. This must be identified in the ISP. a. The participant/participant's representative is required to submit a request in writing to the CM. b. The participant/participant's representative, CM and HH Agency will meet to develop the HHA respite plan.			

c. The HHA plan for providing respite services must include but not limited to: i. Which approved primary care givers will be available to the HHA; ii. Which approved primary care givers will be providing services which are outside the HHA scope of practice; iii. Specific hours respite services will be provided. The HHA will not provide 24 continuous hours of respite; d. The services provided must be within the scope of the HHA skills as identified in the MFW HHA standards; e. A HH Agency RN or LPN must be available for back-up emergency services. d. The services provided must be within the scope of the HHA skills as identified in the MFW HHA standards; e. A HH Agency RN or LPN must be available for back-up emergency services. **B. Agency Provider Requirement** 1. The agency is responsible to ensure that the direct support professionals (RN, LPN, and HHA) meet all applicable MFW, State and Federal requirements for PDN and HHA. 2. The agency will follow the MFW PDN and HHA Standards. 3. Respite services must be provided by qualified personnel as delineated in the agency's licensure requirements and follow the MFW Standards and the MFW Provider Agreement. **<u>NMAC 7.28.2.30</u> HOME HEALTH AIDE TRAINING REQUIREMENTS:** **A. General:** No agency licensed pursuant to these regulations may employ an individual as a home health aide on a full-time, part-time, temporary, per diem, or other basis unless:			

(1) that individual is competent to provide services as a home health aide; **(2)** that individual has completed a training program or a competency evaluation program as outlined in Subsections C or E of 7.28.2.30 NMAC of these regulations. **C. Course requirements:** Home health aides: The home health aide training program must address each of the subject areas listed below through classroom and supervised practical training totaling at least 75 hours, with at least 16 hours devoted to supervised practical training. "Supervised practical training" means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or licensed practical nurse. **(1)** the individual being trained must complete at least 16 hours of classroom training before beginning the supervised practical training; **(2)** communications skills; **(3)** observation, reporting and documentation of patient status and the care or service furnished; **(4)** reading and recording of vital signs; **(5)** basic infection control procedures; **(6)** basic elements of body functioning and changes in body function that must be reported to an aide's supervisor; **(7)** maintenance of a clean, safe and healthy environment; **(8)** recognizing emergencies and knowledge of emergency procedures (including CPR and first aid); **(9)** the physical, emotional and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, his or her privacy and his or her property; **(10)** appropriate and safe techniques in personal hygiene and grooming that include,			

but are not limited to, bathing, shampooing, nail and skin care, oral hygiene and toileting; **(11)** safe transfer techniques and ambulation; **(12)** normal range of motion and positioning; **(13)** nutrition and hydration; **(14)** patient/client rights, including respect for cultural diversity; **(15)** any other task that the home health agency may choose to have the home health aide perform. **NMAC 7.28.2.30.F. Annual in-service training:** Each home health aide must participate in at least 12 documented hours of in-service training during each 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.G. Annual performance review:** A performance review, including written evaluation and skills demonstration must be completed on each home health aide no less frequently than every 12 months. [7.28.2.30 NMAC - Rp 7 NMAC 28.2.30, 11/10/2020]			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Administrative Requirements:			
TAG # MF103 **Continuous Quality Improvement System**			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **I. PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. C. All providers must be currently enrolled as a MFW provider through the Developmental Disabilities Supports Division (DDSD) Provider Enrollment Unit process: a. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures. b. All provider agencies that enter a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies and standards. c. Reference: http://dhi.health.state.nm.us/ D. All agencies must follow all applicable DDSD Policies and Procedures. **III. CONTINUOUS QUALITY MANAGEMENT SYSTEM** A. On an annual basis, MFW provider agencies are required to update and implement the Continuous Quality Improvement Plan. At the	Based on record review, of the Agency's Administrative documentation the Agency did not maintain evidence of the implementation of the Continuous Quality Improvement Plan. **During the survey the following was not found:** • No evidence was found of the Agency's annual summary (February 2020) of the Agency's Quality Improvement activities and resolution which was formally reviewed and approved by the governing body and advisory group of the home health agency and was submitted to the Provider Enrollment Unit and the DDSD (MFW Manager) on/or before February 15th of each calendar year.	**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?)*: →	

time of the DHI audit or upon request, the agency will submit a summary of each year's quality improvement activities and resolutions to the Provider Enrollment Unit. B. 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 State statutes, rules and standards. The agency must review the policies and procedures every three years and update as needed. C. Appropriate planning must take place with all Interdisciplinary Team (IDT) members, Medicaid state plan provider, other waiver providers and school services to facilitate a smooth transition from the MFW Program. The person's choices are given consideration whenever possible DOH policies must be adhered to during this process as per the provider's contract. D. All provider agencies, in addition to requirements under each specific service standard, are required to develop, implement, and maintain, at the designated main agency office, documentation of policies and procedures, for the following: a. Coordination with other provider agency staff serving individuals receiving MFW services that delineates the specific roles of each agency staff. b. Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated. c. Agency protocols for disaster planning and emergency preparedness. **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., admissions, discharges, total visits by discipline, etc.), summary of quality improvement activities, summary of patient/client complaints and resolutions, 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 or may direct the agency to conduct specific quality improvement studies. [7.28.2.39 NMAC - Rp/E 7 NMAC 28.2.39, 6/5/2020] **Provider Application** New Mexico Department of Health Developmental Disabilities Support Division - Provider Enrollment Unit / Development Disabilities Waiver – Medically Fragile Waiver Revised January 2020 **MF Waiver Authoritative Documents**			

21. Quality Assurance/Quality Improvement Plan **22.** Preparation of the Annual Report; The provider agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency and made available upon request.			

TAG # MF04 General Provider Requirements			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **GENERAL PROVIDER REQUIREMENTS** **I. PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. D. All agencies must follow all applicable DDSD Policies and Procedures. E. All provider agencies that enter in to a contractual relationship with DOH to provide MFW services which 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. **III. CONTINUOUS QUALITY MANAGEMENT SYSTEM** B. 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 State statutes, rules and standards. The agency must review the policies and procedures every three years and update as needed.	Based on record review, the Agency's Administrative documentation the Agency did not maintain evidence of the policies and procedures that comply with MFW Standards. **Review of the Agency's Policies and Procedures found no evidence of that the following were reviewed, revised and/or updated at least every three years for following:** • Disaster Planning and Emergency Preparedness • Transition and Discharges • Coverage and Emergency Back Up Plan • On-Call / After Hours Policy and Procedure	**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 1A28 Incident Management System			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **I. PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD. C. All providers must be currently enrolled as a MFW provider through the Developmental Disabilities Supports Division (DDSD) Provider Enrollment Unit process: a. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures. b. All provider agencies that enter a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies and standards. c. Reference: http://dhi.health.state.nm.us/ D. All agencies must follow all applicable DDSD Policies and Procedures. **<u>NMAC 7.1.14.8</u> INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** A. Duty to report: **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers.	Based on record review, the Agency did not establish and/or maintain documentation of the Incident Management System for reporting Abuse, Neglect and Exploitation. **Review of the Agency's Policies / Procedures found the following:** • Per the Agency's "NM Incident Management ANE Reporting…Incident Reporting/ANE (Abuse, Neglect, Exploitation)" Policy indicates, **"**Suspected or known Abuse, Neglect & Exploitation will be reported as required by law to appropriate state agencies (e.g. Adult Protective Services, Child Protective Service, Law enforcement, Department of Health)." *(Note: As required by NMAC 7.1.14 the agency is also required to report the DOH / DHI / IMB.)*	**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?)*: →	

(2) All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **B. Training curriculum:** Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic			

reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer. **C. Incident management system training curriculum requirements:** **(1)** The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to: **(a)** an overview of the potential risk of abuse, neglect, or exploitation; **(b)** informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths; **(d)** specific instructions on how to respond to abuse, neglect, or exploitation; **(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury. **(2)** All current employees and volunteers shall receive training within 90 days of the effective date of this rule. **(3)** All new employees and volunteers shall receive training prior to providing services to consumers. **D. Training documentation:** All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting			

instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Medicaid Billing/Reimbursement			
TAG # MF29 Home Health Aide – Reimbursement			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) Effective July 1, 2019 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **VI. DOCUMENTATION** A. Provider agencies must maintain all records necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to individuals who are currently receiving services. The provider agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, level of services, and length of service billed. B. The documentation of the billable time spent with an individual are kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record must contain at least the following information: a. date and start and end time of each service encounter or other billable service interval; b. description of what occurred during the encounter or service interval; and c. signature and title of staff providing the service verifying that the service and time are correct. **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	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 1 of 7 Individuals. **Individual #7:** October 2020 • The Agency billed 6.0 hours of Home Health Aide Services (S9122 U1) on 10/3/2020. Documentation received account for 5.5 hours. • The Agency billed 6.0 hours of Home Health Aide Services (S9122) on 10/10/2020. Documentation received account for 5.5 hours. • The Agency billed 6.0 hours of Home Health Aide Services (S9122 U1) on 10/17/2020. Documentation received account for 5.5 hours. • The Agency billed 6.0 hours of Home Health Aide Services (S9122 U1) on 10/24/2020. Documentation received account for 5.5 hours. • The Agency billed 6.0 hours of Home Health Aide Services (S9122 U1) on 10/31/2020. Documentation received account for 5.5 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?)*: →	

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-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 through the children's EPSDT program. E. The Medicaid benefit is the payer of last resort. Payment 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 services. G. The HH Agency must follow all current billing requirements by the HSD and the DOH for HHA services. H. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.			

I. Providers of service have the responsibility to review and assure that the information on 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. J. 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 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 without agency approval; 6. Pick up and/or delivery of commodities; and 7. Other non-Medicaid reimbursable activities. **RESPITE STANDARDS** **III. REIMBURSEMENT** Each provider agency of a service is responsible for developing clinical documentation that identifies the direct support professionals' role in all components of the provision of home care, including assessment information, care planning, intervention, communications, and care coordination and evaluation. There must be justification in each person's clinical record supporting medical necessity for the care and for the approved Level of Care, that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant's representative, other caregivers as applicable. All services provided,			

claimed, and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget. A. Payment for respite services through the MFW is considered payment in full. B. The respite services must abide by all Federal, State and Human Services Department (HSD) and DOH policies and procedures regarding billable and non-billable items. C. All billed services must not exceed the capped dollar amount for respite services. D. Reimbursement for respite services will be based on the current rate allowed for the services. E. The agency must follow all current billing requirements by the HSD and DOH for respite services. F. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC. G. Service providers have the responsibility to review and assure that the information on the MAD 046 form is current. If the provider identifies an error, he/she will contact the CM or a supervisor at the case management agency immediately to have the error corrected. H. The MFW Program does not consider the following to be respite service duties and will not authorize payment for: 1. Performing errands for the participant/participant's representative or family that is not program specific; 2. "Friendly visiting," meaning visiting with the person outside of respite work scheduled; 3. Financial brokerage services, handling of participant finances or preparation of legal documents; 4. Time spent on paperwork or travel that is administrative for the provider;			

5. Transportation of the medically fragile participant; 6. Pick up and/or delivery of commodities; and 7. Other non-Medicaid reimbursable activities. **NMAC 8.314.3.17 Reimbursement:** Waiver service providers must submit claims for reimbursement to MAD's fiscal contractor for processing. Claims must be filed per the billing manual. Providers instructions in the Medicaid policy must follow all Medicaid billing instructions. See Section 8.302.2 NMAC. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to providers of Medicaid waiver services is made at a predetermined reimbursement rate. [8.314.3.17 NMAC - Rp, 8 .314.3.17 NMAC, 3/1/2018]			

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DR. TRACIE C. COLLINS, M.D.
Secretary-Designate

Date: April 8, 2021

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

E-mail Address: jennieo@harmonyhomehealth.com

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

E-Mail Address: anithat@harmonyhomehealth.com

Region: Metro and Northeast
Survey Date: December 7 - 18, 2020
Program Surveyed: Medically Fragile Waiver (MFW)

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

Survey Type: Routine

Dear Ms. Osness:

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Monica Valdez, BS

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

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