NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DAVID R. SCRASE, M.D.
Acting Cabinet Secretary

Date:	March 24, 2022
To:	Theresa Paniagua, Home Health Care Administrator and Brett Gladden, Director of Operations
Provider: Address: State/Zip:	Basin Coordinated Health Care, Inc. 210 N. Orchard Avenue Farmington, New Mexico 87401
E-mail Address:	TPaniagua@basin.health
Region: Survey Dates:	Northwest February 28 – March 9, 2022
Program Surveyed:	Medically Fragile Waiver (MFW)
Service(s) Surveyed:	Home Health Aide (HHA), Private Duty Nursing (PDN), Respite HHA
Survey Type:	Routine
Team Leader:	Jamie Pond, BS, QMB Staff Manager, Division of Health Improvement/Quality Management Bureau
Team Members:	Alyssa Swisher, RN, BSN, Nurse Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Paniagua and Mr. Gladden:

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 as deficiencies:

- Tag # MF22 Private Duty Nursing: Scope of Services – Plans / Assessments

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

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.

If you have questions about the Report of Findings or Plan of Correction, please call the Plan of Correction Coordinator, Monica Valdez at (505) 273-1930. Thank you for your cooperation and for the work you perform.

Sincerely,

Jamie Pond, BS

Jamie Pond, BS
QMB Staff Manager / Team Lead
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	February 28, 2022
Contact:	**Basin Coordinated Health Care, Inc.** Theresa Paniagua, Administrator **DOH/DHI/QMB** Jamie Pond, BS, QMB Staff Manager / Team Lead
Entrance Date:	*Agency waived entrance meeting*
Exit Date:	March 9, 2022
Present:	**Basin Coordinated Health Care, Inc.** Theresa Paniagua, Administrator Mary Nelson, Vice President of Operations Brett Gladden, Director of Operations Julie McKeen, Human Resources Ethelinda Whitey, RN Supervisor **DOH/DHI/QMB** Jamie Pond, BS, QMB Staff Manager / Team Lead Alyssa Swisher, RN, BSN, Nurse Healthcare Surveyor **DDSD – Clinical Services Bureau** Iris Clevenger, RN, MFW Program Manager Mary "Nettie" DeBerry, RN, DDSD Nurse Consultant / Generalist
Administrative Locations Visited:	0 *(Note: No administrative locations visited due to COVID-19 Pandemic Public Health Emergency.)*
Total Sample Size:	3 3 – Home Health Aide 2 – Private Duty Nursing 1 – Respite Home Health Aide
Total Homes Observed via Video:	1 *(Note: No home visits conducted due to COVID-19 Public Health Emergency, however, Video Observations were conducted)*
Recipient Served Not Seen:	2 *(Note: Phone interview conducted for Individual #1; Individual #3 declined interview and observation.)*
Recipient Served Records Reviewed:	3
Recipient/Family Members Interviewed:	2 *(Note: Interviews conducted via video / phone due to COVID-19 Public Health Emergency. One additional Individual / family member was unable to be reached for the interview).*
Home Health Aide Records Reviewed:	4 *(One HHA provides dual roles as HHA Respite staff)*
Home Health Aide Interviewed:	4 *(Note: Interviews conducted via video / phone due to COVID-19 Public Health Emergency)*
Private Duty Nursing Records Reviewed:	1

Private Duty Nursing Interviewed:	1 *(Note: Interviews conducted via video / phone due to COVID-19 Public Health Emergency)*
Respite HHA Records Reviewed:	1 *(1 HHA Respite provides dual roles as HHA staff)*
Respite HHA Interviewed:	1 *(Note: Interviews conducted via video / phone due to COVID-19 Public Health Emergency)*
RN Supervisor Record(s) Reviewed:	1
RN Supervisor(s) Interviewed:	1 *(Note: Interviews conducted via video / phone due to COVID-19 Public Health Emergency.)*
Administrative Personnel Interviewed:	2 *(Note: Interviews conducted via video / phone due to COVID-19 Public Health Emergency)*

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Individuals Agency Case Files
- Internal Incident Management System Process and Reports
- Personnel Files – including nursing and subcontracted staff
- Staff Training Records, including staff training hours and staff competency reviews
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Cardiopulmonary Resuscitation (CPR) and First Aid Certifications 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 electronically, or 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): **Basin Coordinated Health Care, Inc. / Northwest**
Program: Medically Fragile Waiver
Service: Home Health Aide (HHA), Private Duty Nursing (PDN), Respite Home Health Aide
Survey Type: Routine
Survey Dates: **February 28 – March 9, 2022**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Record Requirements:			
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 **<u>PRIVATE DUTY NURSING</u>** **I. SCOPE OF SERVICE** **B. Private Duty Nursing Services Include:** 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	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 3 of 3 Individuals. **CMS-485 reviewed by RN Supervisor or RN designee at least every 60 days as required:** • Not Found (#3) **CMS-485 not reviewed by RN Supervisor or RN designee at least every 60 days as required for the following:** • **Individual** #1 – Not found for the following certification period(s): 5/22/2021 – 7/20/2021. • **Individual #1** ➢ CMS-485 reviewed by RN Supervisor or RN designee on 12/31/2020; next certification period not reviewed until 3/10/2021 for certification period covering 3/23/2021 – 5/21/2021. Review period exceeded the 60 day requirement. ➢ CMS-485 reviewed by RN Supervisor or RN designee on 9/23/2021; next certification period not reviewed until 12/21/2021 for certification period covering 11/18/2021 –	**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?)*: →	

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, 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	1/18/2022. Review period exceeded the 60 day requirement. • **Individual #2** ➢ CMS-485 reviewed by RN Supervisor or RN designee on 3/16/2021; next certification period not reviewed until 6/15/2021 for certification period covering 5/20/2021 – 7/18/2021. Review period exceeded the 60 day requirement. ➢ CMS-485 reviewed by RN Supervisor or RN designee on 9/23/2021; next certification period not reviewed until 2/4/2022 for certification period covering 11/16/2021 – 3/16/2022. Review period exceeded the 60 day requirement.		

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.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Standard of Care
Tag # 1A12 All Services Reimbursement	**No Deficient Practices Found**		
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 1/01/2011 **Private Duty Nursing IV. <u>REIMBURSEMENT</u>** Each provider of a service is responsible for providing clinical documentation that identifies the DSP's role in all components of the provision of home care: including assessment information, care planning, intervention, communications and care coordination and evaluation. There must be justification in each participant's medical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of care. Services must be reflected in the ISP that is coordinated with the participant/participant's representative, other caregivers as applicable, and authorized by the approved budget. All services provided, claimed and billed must have documented justification supporting medical necessity and be covered by the MFW. A. Payment for PDN services through the Medicaid waiver is considered payment in full. B. PDN services must abide by all Federal, State and HSD and DOH policies and procedures regarding billable and non-billable items. C. Billed services must not exceed the capped dollar amount for LOC. D. PDN services are a Medicaid benefit for children birth to 21 years, through the children's EPSDT program. E. The Medicaid benefit is the payer of last resort. Payment for the PDN	Based on record review, the Agency maintained all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving Private Duty Nursing, Home Health Aide, Respite Home Health Aide, for 3 of 3 individuals. *Progress notes and billing records supported billing activities for the months of November 2021, December 2021, and January 2022.*		

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

2. "Friendly visiting," meaning visiting with the participant outside of PDN work scheduled. 3. Financial brokerage services, handling of participant finances or preparation of legal documents. 4. Time spent on paperwork or travel that is administrative for the provider. 5. Transportation of participants. 6. Pick up and/or delivery of commodities. 7. Other non-Medicaid reimbursable activities. **Home Health Aide (HHA)** **IV. REIMBURSEMENT** Each provider of a service is responsible for providing clinical documentation that identifies direct care professional (DCP) roles in all components of the provision of home care, including assessment information, care planning, intervention, communications and care coordination and evaluation. There must be justification in each participant's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant's representative and other caregivers as applicable. All services provided, claimed and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget. A. Payment for HHA services through the Medicaid Waiver is considered payment in full. B. The HHA services must abide by all Federal, State, HSD and DOH policies			

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

1. Performing errands for the participant/participant's representative or family that is not program specific. 2. "Friendly visiting", meaning visits with the participant outside of work scheduled. 3. Financial brokerage services, handling of participant finances or preparation of legal documents. 4. Time spent on paperwork or travel that is administrative for the provider. 5. Transportation of participants. 6. Pick up and/or delivery of commodities. 7. Other non-Medicaid reimbursable activities. **RESPITE CARE** **IV. <u>REIMBURSEMENT</u>** 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 participant'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 representative, other caregivers as applicable. All services provided, claimed, and billed must have			

documentation 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. Service providers have the responsibility to review and assure that the information on the MAS 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.			

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DAVID R. SCRASE, M.D.
Acting Cabinet Secretary

Date: May 2, 2022

To: Theresa Paniagua, Home Health Care Administrator

Provider: Basin Coordinated Health Care, Inc.
Address: 210 N. Orchard Avenue
State/Zip: Farmington, New Mexico 87401

E-mail Address: TPaniagua@basin.health

Region: Northwest
Survey Dates: February 28 – March 9, 2022

Program Surveyed: Medically Fragile Waiver (MFW)

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

Survey Type: Routine

Dear Ms. Paniagua:

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Monica Valdez, BS

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

Q.22.3.MFW.D2337.1.RTN.09.22.122