NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

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

Date:	November 16, 2021
To:	Selinda Turner, Executive Director / Community Supports Coordinator
Provider: Address: State/Zip:	La Bella Vida, LLC 2561 Sandia Loop NE Rio Rancho, New Mexico 87144
E-mail Address:	siturner@spinn.net
Region: Survey Date:	Metro, Northwest, Southwest October 18 - 27, 2021
Program Surveyed:	Supports Waiver
Service Surveyed:	***2020:*** Community Support Coordination
Survey Type:	Initial
Team Leader:	Valerie V. Valdez, MS, Bureau Chief, Division of Health Improvement/Quality Management Bureau
Team Members:	Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Kayla Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Turner;

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 Participants receiving services through the Support 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 agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Participants 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:

- SW1A26 Consolidated On-line Registry Employee Abuse Registry
- SWP03.1 Orientation and Enrollment
- SWP06 Service Model and CSC Support Related
- SWP09 ISP Development Process and Required Components
- SWP10 Monitoring & Evaluation of Ongoing Services

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 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

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

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Billing Deficiencies:
If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a "Void/Adjust" 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 contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@state.nm.us 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,

Valerie V. Valdez, M.S.

Valerie V. Valdez, M.S.
Bureau Chief
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	10/18/2021
Contact:	**La Bella Vida, LLC** Selinda Turner, Executive Director **DOH/DHI/QMB** Valerie V. Valdez, M.S., Team Lead / Bureau Chief
On-site Entrance Conference Date:	10/18/2021
Present:	**La Bella Vida, LLC** Selinda Turner, Executive Director / Community Supports Coordinator **DOH/DHI/QMB** Valerie V. Valdez, M.S., Team Lead / Bureau Chief Jamie Pond, BS, Staff Manager / Healthcare Surveyor Lora Norby, Healthcare Surveyor
Exit Conference Date:	10/27/2021
Present:	**La Bella Vida, LLC** Selinda Turner, Executive Director / Community Supports Coordinator **DOH/DHI/QMB** Valerie V. Valdez, Team Lead / Bureau Chief Lora Norby, Healthcare Surveyor Kayla Benally, BSW, Healthcare Surveyor **DDSD – Statewide Supports Waiver** Jennifer Roth, Supports Waiver Program Manager
Administrative Locations Visited:	0 (*Note: No administrative locations visited due to COVID-19 Public Health Emergency*)
Total Sample Size:	2
Persons Served Records Reviewed	2
Total Number of *Secondary Freedom of Choices* Reviewed:	4
Community Support Coordinator Personnel Records Reviewed:	1
Administrative Interviews:	1 *(Note: Interviews conducted by video / phone due to COVID- 19 Public Health Emergency)*

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Participant Program Case Files, including, but not limited to:
  - Individual Service Plans
- Personnel Files, including subcontracted staff

- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Quality Assurance / 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 Participants found to have been affected by the deficient practice.
2. How the agency will identify other Participants who have the potential to be affected by the same deficient practice, and how the agency will act to protect those Participants 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 Participant Served, agency personnel and administrative and service delivery site files are audited by agency personnel to ensure they contain required documents;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Community Support Coordinator 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.

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Personnel Requirements:			
TAG # SW1A26 Consolidated On-line Registry Employee Abuse Registry			
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain, and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 1 of 1 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** • #500 – Date of hire 9/1/2020, completed 9/30/2020.	**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?)*: →	

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.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Record Requirements:			
TAG # SWP03.1 Orientation and Enrollment			
NMAC 8.314.7.16 INDIVIDUAL SERVICE PLAN (ISP) AND AUTHORIZED ANNUAL BUDGET (AAB): (2) Pre-planning: (a) the CSC contacts the eligible recipient upon their choosing enrollment in the supports waiver program to provide information regarding this program, including the range and scope of choices and options, as well as the rights, risks, and responsibilities associated with participation in the supports waiver; (b) the CSC discusses areas of need to address on the eligible recipient's ISP. The CSC provides support during the annual re-determination process to assist with completing medical and financial eligibility in a timely manner **Support Waiver Service Standards Effective 9/1/2020** The Initial Waiver Eligibility phase is 90 days. Any CSC who is assisting a participant who has not established Medicaid eligibility in 90 days will need to receive an extension from DDSD prior to the expiration of the 90 days. Once Medicaid eligibility has been established and the initial ISP and budget are approved, ongoing CSC services begin, and the CSC must schedule an ISP meeting within 10 days. In the Initial Waiver Eligibility and Waiver Enrollment phase the CSC: 1. Contacts the individual within five (5) working days after receiving the PFOC to schedule an initial orientation and enrollment meeting: 2. Conducts a waiver enrollment meeting within 30 days of receiving the PFOC. (Requirements for the waiver enrollment process are described in 16.3.1 Waiver Eligibility	Based on record review, the Agency did not maintain evidence that initial contact was made and processes were followed as indicated by Standards and Regulations for 2 of 2 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: • Evidence the agency assigned a CSC and contact with the new Supports Waiver Participant within five (5) working days of the receipt of the Primary Freedom of Choice or CSC Agency Change Form. (#1) *(Note: Not able to determine as agency failed to document date the PFOC was received.)* • Evidence the orientation / enrollment meeting scheduled within 5 working days of receipt of the PFOC: ➢ Participant #1*:* Not able to determine as agency failed to document date the PFOC was received. ➢ Participant #2: Not able to determine, as agency failed to document date initial meeting was scheduled. • Evidence the assigned CSC conducted the waiver enrollment meeting within 30 days of the PFOC being received. (#1) *(Note: Not able to determine as agency failed to document date the PFOC was received.)*	**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?)*: →	

Recertification and Program Paperwork) Informs, supports, and assists new Supports Waiver participants with the requirements for establishing Level of Care (LOC) within ninety (90) calendar days of receiving the PFOC following processes described in 16.3.3 Medical Eligibility. 3. Educates the participant regarding the required documentation and submission process to establish Financial Eligibility and monitors the status of the submission of the required documentation to ISD. 4. Routinely reports the status of initial participant eligibility to the DOH – DDSD in frequency and format requested by DOH – DDSD. 5. Assist the participant to identify any barriers that may occur during this process. 6. Contacts the participant at least monthly for follow up on initial waiver eligibility and waiver enrollment activities. This contact can be either be face-to face or by telephone but at least one (1) face to face visit is required. 7. Provide as much support as needed during this phase to ensure that the medical and financial eligibility is obtained. 8. As much as possible, conducts service pre-planning during this time to ensure the completion and submission of the initial ISP so that it will be in effect within ninety (90) calendar days off eligibility determination. 9. Shall not to exceed three (3) months of monthly billing. If an extension is granted during this phase by DDSD then the monitoring requirements are subject to DDSD approval. 10. Prior to ISP development or during the development process, obtain a copy of the Approval Letter or verify that the Income Support Division (ISD) office of the Human Services Department (HSD) has completed a determination that the individual meets financial and medical eligibility to participate in the Supports Waiver program.			

11. Schedule an ISP meeting within ten (10) business days of the approval verification from ISD. For those participants transferring from another waiver or benefit program like State General Fund or Centennial Care Community Benefit, the transfer meeting and transfer of program information as referenced in the Supports Waiver transition grid and the waiver change form must occur prior to the ISP meeting and according to HSD- DOH transition guidelines. 12.Submit all Initial Waiver Eligibility/ Waiver Enrollment service billing following the Human Services Department (HSD) instructions available through the Medicaid Provider Portal.			

TAG # SWP06 Service Model and CSC Support Related			
NMAC 8.314.7.9 SUPPORTS WAIVER HOME AND COMMUNITY-BASED SERVICES: A. New Mexico's supports waiver is designed to provide temporary assistance to those on the developmental disabilities (DD) waiver wait list. It is intended to provide support services to eligible recipients to enable work toward self-determination, independence, productivity, integration, and inclusion in all facets of community life across the lifespan. The services provided are intended to build on each eligible recipient's current support structures through person-centered planning to work toward individually defined life outcomes, focusing on developing the eligible recipient's abilities for self-determination, community living and participation, and economic self-sufficiency. An eligible recipient has a choice of receiving services through the agency-based service delivery model or the participant directed service delivery model. **8.314.7.11 ELIGIBLE RECIPIENT RESPONSIBILITIES:** (2) collaborate with the CSC to choose between the agency-based or participant directed service delivery models and determine support needs related to planning and self-direction as applicable. **8.314.7.14 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA:** D. Community supports coordinator: Community support coordination services are intended to educate, guide, and assist the eligible recipient to make informed planning decisions about services and supports, and monitor those services and supports. Specific waiver function(s) that CSC providers have are: (3) educate, train, and assist eligible recipient (and guardian, employer of record) about participant direction or agency-based service delivery models (includes adherence to	Based on record review, the Agency did not maintain documentation assuring participants collaborated with the CSC to choose between the agency-based or participant directed service delivery models for 2 of 2 participants. Review of the Agency participant case files revealed the following items were not found, incomplete, and/or not current: **Service Model Form:** **Agency Based:** • Not Found (#1). *(Note: Per 10/2021 case note the Participant receives agency based services.)* • Incomplete (#2). *(Note: Document did not contain the Participant's name or date it was virtually signed.)*	**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, review of rights, recognizing and reporting critical incidents) **Support Waiver Service Standards Effective 9/1/2020** **CHAPTER 2. SERVICE DELIVERY MODELS** When an individual chooses the Supports Waiver, they also choose the service delivery model. The Community Support Coordinator (CSC) assists the participant in understanding and choosing the service delivery model. **16.3.7 Monitoring during Ongoing Community Support Coordinator Services** Monitoring activities include: 4. Review the participant's exercise of informed choice including choice of CSC, of agency-based provider or participant directed employees and of service delivery model. **16.4 Administrative Requirements** 8. Maintain HIPAA compliant primary records for each participant including, but not limited to: o. Supports Waiver service delivery model change form			

TAG # SWP09 ISP Development Process and Required Components			
NMAC 8.314.7.16 INDIVIDUAL SERVICE PLAN (ISP) AND AUTHORIZED ANNUAL BUDGET(AAB): **(3) ISP components:** The ISP contains: (a) the supports waiver services that are furnished to the eligible recipient, the projected amount, frequency and duration, and the type of provider who furnishes each service; (i) the ISP must describe in detail how the services or goods relate to the eligible recipient's qualifying condition or disability; (ii) the ISP must describe how the services and goods support the eligible recipient to remain in the community and reduce their risk of institutionalization; and (iii) the ISP must specify the hours of services to be provided and payment arrangements. (b) other services needed by the supports waiver eligible recipient regardless of funding source, including state plan services; **(**c) informal supports that complement supports waiver services in meeting the needs of the eligible recipient; (d) methods for coordination with the Medicaid state plan services and other public programs; (e) methods for addressing the eligible recipient's health care needs when relevant; (f) quality assurance criteria to be used to determine if the services and goods meet the eligible recipient's needs as related to their qualifying condition or disability; (g) information, resources, or training needed by the eligible recipient and service providers; (h) methods to address the eligible recipient's health and safety, such as emergency and back-up services. **Support Waiver Service Standards Effective 9/1/2020** **8.1 Sections of the Individual Service Plan (ISP)**	Based on record review, the Community Support Coordinator agency did not ensure all requirements of Individual Service Plan (ISP) development were followed as indicated by Standards for 1 of 2 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: **ISP did not contain the purposes of services, expected outcomes, and methods for monitoring the contents of the ISP:** • Not Found for questions #9 in the ISP. Question was blank and did not indicate N/A if it was not applicable (#1)	**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 Supports Waiver ISP template is available on the Supports Waiver website and will be provided to Supports Waiver participants as a pre-planning document. It is organized by several sections including four (4) categories of services and emergency back-up plan. In each section, questions help identify the participant's strengths, goals, natural and informal supports, concerns, and challenges, and how the participant will know whether the plan they have developed is working well. Because the ISP is a comprehensive planning tool, all areas need to be considered carefully. Each section of the ISP must be completed, even if the participant does not plan to request services or goods from that section. The ISP can be written out by hand or in the Word version of the form. **Personal Care Services** The first section of the ISP covers supports that help the participant stay in his/her own home and community. These supports can provide needed assistance with activities of daily living, home management, supports for health and safety. Supports are provided through Personal Care Services. **Community Membership Supports** Community Membership Supports help with participation in community life in order to enhance relationships with others, work or participate in meaningful activities. These supports include: Supported Employment and Customized Community Supports Group and Individual. **Health and Wellness Supports** The third section of the ISP covers Health and Wellness Supports. This area identifies the participants needs and identifies where the participant will access waiver and non-waiver services to address those needs. The service provided by the Supports Waiver in this category is Behavior Support Consultation. Some Assistive Technology devices and equipment available through the Supports			

Waiver may be linked to health-related issues and may be ordered or recommended by a licensed primary care practitioner or therapist. The participant and CSC may need to research and/or interview Support Consultants to address whether or not the particular behavioral health need can be fulfilled via the BSC of the Supports Waiver or should be directly asked for of the behavioral health system (via EPSTDT, Medicaid State plan or Medicare). **Other Supports** The fourth section of the ISP addresses other supports that are available to enhance or enable the participant to receive other services on his/her plan, thereby increasing his/her independence and potentially decreasing the need for more specialized or direct services. In the Supports Waiver these supports include: Vehicle Modification, Non-medical Transportation, Respite, and Assistive Technology. **Other Sections of the ISP** The ISP also includes a section for Environmental Modification services which are physical adaptations that provide medical or remedial benefits to the individual's physical environment that address the qualifying diagnosis. **Quality Assurance Criteria** The ISP contains the quality assurance criteria to be used to determine if the service or goods meet the participant's need as related to the qualifying diagnosis. **24-Hour Emergency Back-Up Plan** This section lists who the participant will contact in an emergency or if regularly scheduled employees or service providers are unable to report to work. The Emergency Back-Up Plan is mandatory and must be completed in the ISP. The individuals or agencies who provide back-up services if regularly scheduled employees who are not available are responsible for ensuring			

continuity of services and providing care while new employees are being on-boarded. An agency who is providing services is required to be listed on the emergency back-up plan and to provide back-up employees. **Community Supports Coordinator** The last section of the ISP addresses how much help the participant may need from the CSC to be successful. For example, a participant needs two calls a month from CSC when beginning with a new provider or a participant needs additional support during medical and financial eligibility process.			

TAG # SWP10 Monitoring & Evaluation of Ongoing Services			
Support Waiver Service Standards Effective 9/1/2020 **16.3 Ongoing CSC Services** The CSC assists the participants with implementation and quality assurance related to the ISP and Authorized Annual Budget (AAB). CSC services provide support to participants to maximize their ability to access and direct their Supports Waiver participation through an agency-based service delivery model or participant directed service delivery model. **16.3.1 Annual Waiver Eligibility Recertification and Program Paperwork** The CSC conducts a program meeting annually. This meeting consists of providing program information and completing annual paperwork prior to the expiration of the budget term. Paperwork and forms related to Supports Waiver issued by the State must remain in their original format. The meeting may have to be conducted in two or more parts to assure meaningful review of all the necessary information. The CSC role is to: 1. Educate the participant and legal representatives regarding Supports Waiver Program Guiding Principles and Requirements; including the person-centered planning process, determining circle of support and participant rights; 2. Discuss medical and financial eligibility requirements and discuss the process for establishing both; 3. Educate and assist the participant in selecting agency-based or participant-directed services and document the participants selection; 4. Provide information regarding Support Waiver roles and responsibilities, including key agencies and supports and contact information; 5. Complete the Participant Responsibilities Form and the HCBS Consumer Rights and	Based on record review, the Agency did not use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the participant for 1 of 2 participants. **Review of the Agency Participant case files revealed no evidence indicating quarterly face-to-face or virtually visits were completed as required for the following Participants:** • Participant #2 – No Quarterly documentation found between 6/2021 – 10/2021. *(Note: Agency completed monthly contacts, however, none were documented as a quarterly.)*	**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?)*: →	

Freedoms Form; 6. Review the Support Waiver Service Standards with the participant. Based on the preference of the participant provide a written copy of the Standards, assist the participant to access the Standards on-line or provide both. 7. Review the CSC agency grievance process; 8. Clearly educate the participant that any use of restraint, restriction and seclusion is not allowed on the Supports Waiver; 9. Provide information to participants related to recognizing and reporting abuse, neglect, exploitation, suspicious injury or any participant death and environmentally hazardous conditions which create an immediate threat to life; 10. Provide and review all enrollment information identified by DOH/DDSD. 11. For participants who have chosen the agency-directed services, discuss the Secondary Freedom of Choice Process; 12. For participants who have chosen participant-directed services: a. Discuss the Employer of Record (EOR), complete the EOR Questionnaire, and complete the EOR Information Form (for annual meeting only if there is a change); b. Review the process for hiring employees and contractors and required paperwork; c. Discuss the background check and other credentialing requirements for employees and contractors; d. Provide initial and ongoing education and guidance to support participants and EORs with understanding their role as detailed in EOR Guide; e. Provide assistance participants with problems solving employee and vendor payment issues with the FMA and other relevant parties; f. Provide initial education and ongoing assist the participant to identify and access other resources for training employees(s)/service provider (s), if applicable; and			

g. Provide initial education and ongoing assistance to the participant in managing their budget, reviewing budget expenditures; and preparing and submitting revisions.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI, Responsible Party	Completion Date
Medicaid Billing/Reimbursement:			
TAG # SW1A12 All Services Reimbursement	**No Deficient Practices Found**		
Support Waiver Service Standards Effective 9/1/2020 **16.2 Initial Waiver Eligibility and Waiver Enrollment Activities** 9. Shall not to exceed three (3) months of monthly billing. If an extension is granted during this phase by DDSD then the monitoring requirements are subject to DDSD approval. **16.7 CSC Reimbursement** CSC services shall be reimbursed based upon a per-member/per-month unit. A maximum of one (1) unit per month can be billed per each participant. Provider records are subject to post payment reviews and must be sufficiently detailed to substantiate the nature, quality, and amount of CSC services provided. Post payment reviews may result non-payment or recoupment. 1. There is a maximum of twelve (12) billing units per participant per ISP year. 2. A maximum of one unit per month can be billed per each participant receiving CSC services. 3. The CSC provider/agency shall provide the level of support required by the participant. 4. A minimum of four (4) face to face quarterly visits are required per ISP year, with two face to face visits being in the home. 1. One of the quarterly faces to face meetings must include the development of the annual ISP and assistance with the LOC assessment.	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 for 2 of 2 Participants. *Contact notes and billing records supported billing activities for the months of July, August and September 2021.*		

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

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

Date: January 7, 2022

To: Selinda Turner, Executive Director / Community Supports Coordinator

Provider: La Bella Vida, LLC
Address: 2561 Sandia Loop NE
State/Zip: Rio Rancho, New Mexico 87144

E-mail Address: siturner@spinn.net

Region: Metro, Northwest, Southwest
Survey Date: October 18 - 27, 2021

Program Surveyed: Supports Waiver

Service Surveyed: ***2020:*** Community Support Coordination

Survey Type: Initial

Dear Ms. Turner:

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.22.2.SW. 50780298.1,3,5.INT.09.21.007