NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date:	February 20, 2023
To:	Angela Ledesma, Executive Director
Provider: Address: State/Zip:	Angel Care of New Mexico, Inc. 2225 E. Griggs Ave. Las Cruces, New Mexico 88001
E-mail Address:	Angela@angelcarenm.net
Region: Survey Date:	Southwest January 17 - 27, 2023
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Family Living and Customized Community Supports
Survey Type:	Routine
Team Leader:	Jorge Sanchez-Enriquez, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Lei Lani Nava, MPH, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Kaitlyn Taylor, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Ledesma;

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 Developmental Disabilities 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 Individuals served at risk of harm.

Determination of Compliance:

The Division of Health Improvement, Quality Management Bureau has determined your agency is in:

Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags: This determination is based on noncompliance with one to five (1 – 5) Condition of Participation Level Tags *(refer to Attachment D for details)*. The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A15.2 Administrative Case Files: Healthcare Documentation (Therap and Required Plans)
- Tag # 1A31 Client Rights/Human Rights
- Tag # LS25.1 Residential Reqts. (Physical Environment – Supported Living / Family Living / Intensive Medical Living)

The following tags are identified as Standard Level:

- Tag # 1A08.1 Admirative and Residential Case File: Progress Notes
- Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)
- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- Tag # LS14.1 Residential Service Delivery Site Case File (Other Required Documentation)
- Tag # 1A22 Agency Personnel Competency
- Tag # 1A37 Individual Specific Training
- Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider
- Tag #1A29 Complaints / Grievances Acknowledgment
- Tag # LS25 Residential Health & Safety (Supported Living & Family Living)

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, Monica Valdez, Plan of Correction Coordinator** at MonicaE.Valdez@doh.nm.gov

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
PO Box 2348
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@hsd.nm.gov)

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
5300 Homestead Rd NE, Suite 300-3223
Albuquerque, NM 87110
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@doh.nm.gov 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,

Jorge Sanchez-Enriquez, BS

Jorge Sanchez-Enriquez, BS.
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	January 17, 2023
Contact:	**Angel Care of New Mexico, Inc.** Angela Ledesma, Executive Director **DOH/DHI/QMB** Jorge Sanchez-Enriquez, BS, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	January 17, 2023
Present:	**Angel Care of New Mexico, Inc.** Angela Ledesma, Executive Director Suzann Ochoa, DSP / Service Coordinator Jessica Guzman, Service Coordinator **DOH/DHI/QMB** Jorge Sanchez-Enriquez, BS, Team Lead/Healthcare Surveyor Lei Lani Nava, MPH, Healthcare Surveyor Kaitlyn Taylor, BSW, Healthcare Surveyor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor
Exit Conference Date:	January 27, 2023
Present:	**Angel Care of New Mexico, Inc.** Angela Ledesma, Executive Director Suzann Ochoa, DSP / Service Coordinator Jessica Guzman, Service Coordinator **DOH/DHI/QMB** Jorge Sanchez-Enriquez, BS, Team Lead/Healthcare Surveyor Lei Lani Nava, MPH, Healthcare Surveyor Kaitlyn Taylor, BSW, Healthcare Surveyor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor **DDSD – SW Regional Office** Jacqueline Marquez, Social & Community Service Coordinator
Administrative Locations Visited:	0 *(Administrative portion of survey completed remotely)*
Total Sample Size:	11 0 - *Former Jackson Class Members* 11 - Non-*Jackson* Class Members 8 - Family Living 11 - Customized Community Supports
Total Homes Visited In-Person	8
❖ Family Living Homes Visited	8
Persons Served Records Reviewed	11
Persons Served Interviewed	9

Persons Served Observed	1 *(Note: 1 individual was observed, as individual refused interview)*
Persons Served Not Seen and/or Not Available	1 *(Note: 1 Individual was not available during the on-site survey)*
Direct Support Professional Records Reviewed	54 *(One DSP performs dual roles as a DSP and SC)*
Direct Support Professional Interviewed	13
Substitute Care/Respite Personnel Records Reviewed	14
Service Coordinator Records Reviewed	2 *(One SC performs dual roles as a DSP)*
Nurse Interview	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
    - °Individual Service Plans
    - °Progress on Identified Outcomes
    - °Healthcare Plans
    - °Medical Emergency Response Plans
    - °Medication Administration Records
    - °Physician Orders
    - °Therapy Evaluations and Plans
    - °Healthcare Documentation Regarding Appointments and Required Follow-Up
    - °Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- Quality Assurance / Improvement Plan
- Family Living Home Study
- Monthly face-to-face Consultations

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@doh.nm.gov. 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@doh.nm.gov 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 via email at MonicaE.valdez@doh.nm.gov. Please also submit your POC to your Developmental Disabilities Supports Division Regional Office for region of service surveyed.
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. You must also submit evidence of the ongoing Quality Assurance/Quality Improvement processes.

1. Your internal documents are due within a *maximum* of 45-business days of receipt of your Report of Findings.
2. Please submit your documents electronically according to the following: If documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to the State email account. If documents contain PHI **do not** submit PHI directly to the State email account. *You may submit PHI **only** when **replying** to a **secure** email received from the State email account*. When possible, please submit requested documentation using a "zipped/compressed" file to reduce file size. You may also submit documents via S-Comm (Therap), or another electronic format, i.e., flash drive.
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 due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

Attachment B

Department of Health, Division of Health Improvement
QMB Determination of Compliance Process

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and other state and federal regulations. For the purpose of the LCA / CI survey the CMS waiver assurances have been grouped into four (4) Service Domains: Plan of Care (ISP Implementation); Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Assurance system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

Each deficiency in your Report of Findings has been predetermined to be a Standard Level Deficiency, a Condition of Participation Level Deficiency, if below 85% compliance or a non-negotiable Condition of Participation Level Deficiency. Your Agency's overall Compliance Determination is based on a Scope and Severity Scale which takes into account the number of Standard and Condition Level Tags cited as well as the percentage of Individuals affected in the sample.

Conditions of Participation (CoPs)

CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances, in addition to the New Mexico Developmental Disability Waiver (DDW) Service Standards. The Division of Health Improvement (DHI), in conjunction with the Developmental Disability Support Division (DDSD), has identified certain deficiencies that have the potential to be a Condition of Participation Level, if the tag falls below 85% compliance based on the number of people affected. Additionally, there are what are called non-negotiable Conditions of Participation, regardless if one person or multiple people are affected. In this context, a CoP is defined as an essential / fundamental regulation or standard, which when out of compliance directly affects the health and welfare of the Individuals served. If no deficiencies within a Tag are at the level of a CoP, it is cited as a Standard Level Deficiency.

Service Domains and CoPs for <u>Living Care Arrangements and Community Inclusion</u> are as follows:

<u>Service Domain: Service Plan: ISP Implementation -</u> *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A08.3 –** Administrative Case File: Individual Service Plan / ISP Components
- **1A32 –** Administrative Case File: Individual Service Plan Implementation
- **LS14 –** Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- **IS14 –** CCS / CIES Service Delivery Site Case File (ISP and Healthcare Requirements)

<u>Service Domain: Qualified Providers -</u> *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A20 -** Direct Support Professional Training

- **1A22 -** Agency Personnel Competency
- **1A37 –** Individual Specific Training

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):
- **1A25.1 –** Caregiver Criminal History Screening
- **1A26.1 –** Consolidated On-line Registry Employee Abuse Registry

Service Domain: Health, Welfare and Safety - *The State, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*

Potential Condition of Participation Level Tags, if compliance is below 85%:
- **1A08.2 –** Administrative Case File: Healthcare Requirements & Follow-up
- **1A09 –** Medication Delivery Routine Medication Administration
- **1A09.1 –** Medication Delivery PRN Medication Administration
- **1A15.2 –** Administrative Case File: Healthcare Documentation (Therap and Required Plans)

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):
- **1A05 –** General Requirements / Agency Policy and Procedure Requirements
- **1A07 –** Social Security Income (SSI) Payments
- **1A09.2 –** Medication Delivery Nurse Approval for PRN Medication
- **1A15 –** Healthcare Coordination - Nurse Availability / Knowledge
- **1A31 –** Client Rights/Human Rights
- **LS25.1 –** Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

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@doh.nm.gov 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.

Attachment D

QMB Determinations of Compliance

Compliance:

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or that no deficiencies at the Condition of Participation Level were found. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of *Compliance*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

Partial-Compliance with Standard Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags* indicates that a provider is in compliance with all Condition of Participation Level deficiencies but is out of compliance with a certain percentage of Standard Level deficiencies. This partial-compliance, if not corrected, may result in a negative outcome or the potential for more than minimal harm to individuals' health and safety. There are two ways to receive a determination of Partial Compliance with Standard Level Tags:

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.

2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags. This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety.

Non-Compliance:

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. There are three ways an agency can receive a determination of Non-Compliance:

1. Your Report of Findings includes 17 or more total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level tag.

2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

Compliance Determination	Weighting						
	LOW		MEDIUM			HIGH	
Total Tags:	up to 16	17 or more	up to 16	17 or more	Any Amount	17 or more	Any Amount
	and	and	and	and	And/or	and	And/or
COP Level Tags:	0 COP	0 COP	0 COP	0 COP	1 to 5 COP	0 to 5 CoPs	6 or more COP
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
"Non-Compliance"						**17 or more** Total Tags with **75 to 100%** of the Individuals in the sample cited in any CoP Level tag.	**Any Amount** of Standard Level Tags and **6 or more** Conditions of Participation Level Tags.
"Partial Compliance with Standard Level tags and Condition of Participation Level Tags"					**Any Amount** Standard Level Tags, plus **1 to 5** Conditions of Participation Level tags.		
"Partial Compliance with Standard Level tags"			**up to 16** Standard Level Tags with **75 to 100%** of the individuals in the sample cited in any tag.	**17 or more** Standard Level Tags with **50 to 74%** of the individuals in the sample cited any tag.			
"Compliance"	**Up to 16** Standard Level Tags with **0 to 74%** of the individuals in the sample cited in any tag.	**17 or more** Standard Level Tags with **0 to 49%** of the individuals in the sample cited in any tag.					

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A08.1 Administrative and Residential Case File: Progress Notes	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses,	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 1 of 11 Individuals. Review of the Agency individual case files revealed the following items were not found: **Residential Case File:** **Family Living Progress Notes/Daily Contact Logs:** • Individual #2 - None found for 1/1 – 15, 2023. *(Date of home visit: 1/18/2023).*	**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?)***:** →	

RDs, therapists or BSCs are present in all settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A: Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.			

Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	Standard Level Deficiency		
NMAC 7.26.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY. **NMAC 7.26.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS.** **NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS.** Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 6 Individual Service Plan (ISP)** The CMS requires a person-centered service plan for every person receiving HCBS. The DD Waiver's person-centered service plan is the ISP. **6.6 DDSD ISP Template:** The ISP must be written according to templates provided by the DDSD. Both children and adults have designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e., an acknowledgement of receipt of specific information) and other elements depending on the age and status of the individual. The ISP templates may be revised and reissued by DDSD to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDSD and be required for use to better demonstrate required elements of the PCP process and ISP development. **6.6.1 Vision Statements: The long-term vision statement describes the person's major long-term (e.g., within one to three**	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 11 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Addendum A**: • Not Current (#3)	**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?)*: →	

years) life dreams and aspirations in the following areas: 1. Live, 2. Work/Education/Volunteer, 3. Develop Relationships/Have Fun, and 4. Health and/or Other (Optional). **6.6.2 Desired Outcomes:** A Desired Outcome is required for each life area (Live, Work, Fun) for which the person receives paid supports through the DD Waiver. Each service does not need its own, separate outcome, but should be connected to at least one Desired Outcome. **6.6.3.1 Action Plan:** Each Desired Outcome requires an Action Plan. The Action Plan addresses individual strengths and capabilities in reaching Desired Outcomes. **6.6.3.2 Teaching and Supports Strategies (TSS) and Written Direct Support Instructions (WDSI):** After the ISP meeting, IDT members conduct a task analysis and assessments necessary to create effective TSS and WDSI to support those Action Plans that require this extra detail. **6.6.3.3 Individual Specific Training in the ISP:** The CM, with input from each DD Waiver Provider Agency at the annual ISP meeting, completes the IST requirements section of the ISP form listing all training needs specific to the individual. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.			

Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities.	Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 2 of 11 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #8 • According to the Work/Learn Outcome; Action Step for "… will volunteer" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2022. • According to the Fun Outcome; Action Step for "… will choose a sport" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2022. Individual #10 • According to the Health/Other Outcome; Action Step for "… will pick physical activity of his choice." is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2022.	**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 following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 6 Individual Service Plan (ISP): 6.9** ISP Implementation and Monitoring All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Section II Chapter 20: Provider Documentation and Client Records) CMs facilitate and maintain communication with the person, their guardian, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of their services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Section II Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes	• According to the Health/Other Outcome; Action Step for "… will track his physical activity." is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2022.		

documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.			

Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 6 Individual Service Plan (ISP)** The CMS requires a person-centered service plan for every person receiving HCBS. The DD Waiver's person-centered service plan is the ISP. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 4. Provider Agencies must maintain records of all documents produced by agency	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 1 of 8 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **ISP Teaching and Support Strategies:** ***Individual #9:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "… will measure and detergent to washer." • "… will move wet clean clothes to the dryer." • "… will take dry clothes out of the dryer."	**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?)*: →	

personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A: Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. **20.5.4 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form generated from an e-CHAT in the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications.			

Chapter 13 Nursing Services: 13.2.9.1 Health Care Plans (HCP): Health Care Plans are created to provide guidance for the Direct Support Professionals (DSP) to support health related issues. Approaches that are specific to nurses may also be incorporated into the HCP. Healthcare Plans are based upon the eCHAT and the nursing assessment of the individual's needs. **13.2.9.2 Medical Emergency Response Plan (MERP): 1)** The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions automatically triggered and marked with an "R" in the e-CHAT summary report. The agency nurse should use their clinical judgment and input from. 2) MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.			

Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)	Standard Level Deficiency		
Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 1 of 8 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **Behavior Crisis Intervention Plan:** • Not Found (#10)	**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?)*: →	

service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A: Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A22 Agency Personnel Competency	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 17 Training Requirements** **17.9 Individual-Specific Training Requirements:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence. Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. The trainer must observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on	Based on interview, the Agency did not ensure training competencies were met for 2 of 14 Direct Support Professional. **When DSP were asked, what State Agency do you report suspected Abuse, Neglect or Exploitation to, the following was reported:** • DSP #532 stated, "Umm I would call the Environment Hazards or Community Program." Staff was not able to identify the State Agency as Division of Health Improvement. • DSP #548 stated, "I would call Angel Care." Staff was not able to identify the State Agency as Division of Health Improvement	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported. 1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, Teaching and Support Strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends. 2. IST for therapy-related Written Direct Support Instructions (WDSI), Healthcare Plans (HCPs), Medical Emergency Response Plan (MERPs), Comprehensive Aspiration Risk Management Plans (CARMPs), Positive Behavior Supports Assessment (PBSA), Positive Behavior Supports Plans (PBSPs), and Behavior Crisis Intervention Plans (BCIPs), PRN Psychotropic Medication Plans (PPMPs), and Risk Management Plans (RMPs) must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds problems with implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher. 3. The competency level of the training is based on the IST section of the ISP. 4. The person should be present for and involved in IST whenever possible. 5. Provider Agencies are responsible for tracking of IST requirements. 6. Provider Agencies must arrange and ensure that DSP's and CIE's are trained on			

the contents of the plans in accordance with timelines indicated in the Individual-Specific Training Requirements: Support Plans section of the ISP and notify the plan authors when new DSP are hired to arrange for trainings. 7. If a therapist, BSC, nurse, or other author of a plan, healthcare or otherwise, chooses to designate a trainer, that person is still responsible for providing the curriculum to the designated trainer. The author of the plan is also responsible for ensuring the designated trainer is verifying competency in alignment with their curriculum, doing periodic quality assurance checks with their designated trainer, and re-certifying the designated trainer at least annually and/or when there is a change to a person's plan.			

Tag # 1A37 Individual Specific Training	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 17 Training Requirements: 17.1 Training Requirements for Direct Support Professional and Direct Support Supervisors:** Direct Support Professional (DSP) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports. 1. DSP/DSS must successfully complete within 30 calendar days of hire and prior to working alone with a person in service: a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported and as outlined in Chapter 17.9 Individual Specific Training below. b. Complete DDSD training in standards precautions located in the New Mexico Waiver Training Hub. c. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines. d. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals). e. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, Crisis Prevention and Intervention (CPI)) before using Emergency Physical Restraint (EPR). Agency DSP and DSS shall maintain certification in a DDSD-approved system if any person they support has a BCIP that includes the use of EPR. f. Complete and maintain certification in a DDSD-approved Assistance with Medication Delivery (AWMD) course if	Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 2 of 55 Agency Personnel. Review of personnel records found no evidence of the following: **Direct Support Professional (DSP):** • Individual Specific Training (#532) **Direct Support Supervisory Personnel:** • Individual Specific Training (#553)	**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?)*: →	

required to assist with medication delivery. g. Complete DDSD training regarding the HIPAA located in the New Mexico Waiver Training Hub. **17.1.13 Training Requirements for Service Coordinators (SC):** Service Coordinators (SCs) refer to staff at agencies providing the following services: Supported Living, Family Living, Customized In-home Supports, Intensive Medical Living, Customized Community Supports, Community Integrated Employment, and Crisis Supports. 1. A SC must successfully complete within 30 calendar days of hire and prior to working alone with a person in service: a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported, and as outlined in the Chapter 17.10 Individual-Specific Training below. b. Complete DDSD training in standard precautions located in the New Mexico Waiver Training Hub. c. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines. d. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals). e. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using emergency physical restraint. Agency SC shall maintain certification in a DDSD-approved system if a person they support has a Behavioral Crisis Intervention Plan that includes the use of emergency physical restraint.			

f. Complete and maintain certification in AWMD if required to assist with medications. g. Complete DDSD training regarding HIPAA located in the New Mexico Waiver Training Hub.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag #1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Condition of Participation Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 3 Safeguards: 3.1 Decisions about Health Care or Other Treatment: Decision Consultation and Team Justification** **Process:** There are a variety of approaches and available resources to support decision making when desired by the person. The decision consultation and team justification processes assist participants and their health care decision makers to document their decisions. It is important for provider agencies to communicate with guardians to share with the Interdisciplinary Team (IDT) Members any medical, behavioral, or psychiatric information as part of an individual's routine medical or psychiatric care. For current forms and resources please refer to the DOH Website: https://nmhealth.org/about/ddsd/. **3.1.1 Decision Consultation Process (DCP):** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies and Interdisciplinary Teams (IDTs) are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following: 1. The Decision Consultation Process (DCP) is documented on the Decision Consultation and Team Justification Form (DC/TJF) and is used for health related issues when a person or their guardian/healthcare decision	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 3 of 11 individuals receiving Living Care Arrangements and Community Inclusion. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Living Care Arrangements / Community Inclusion (Individuals Receiving Multiple Services):*** **Annual Physical:** • Not Found (#7, 8, 9)	**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?)*: →	

maker has concerns, needs more information about these types of issues or has decided not to follow all or part of a healthcare-related order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT (e.g., nurses, therapists, dieticians, BSCs or PRS Risk Evaluator) or clinicians who have performed evaluations such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR); and d. recommendations made by a licensed professional through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), a Medical Emergency Response Plan (MERP) or another plan such as a Risk Management Plan (RMP) or a Behavior Crisis Intervention Plan (BCIP). **Chapter 20 Provider Documentation and Client Records: 20.2 Client Record Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the			

location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the			

termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.4 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form generated from an e-CHAT in the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. Requirements for the *Health Passport* and *Physician Consultation* form are: 1. The Case Manager and Primary and Secondary Provider Agencies must communicate critical information to each other and will keep all required sections of Therap updated in order to have a current and thorough *Health Passport* and *Physician Consultation* Form available at all times. Required sections of Therap include the IDF, Diagnoses, and Medication History. 2. The Primary and Secondary Provider Agencies must ensure that a current copy of the *Health Passport* and *Physician Consultation* forms are printed and available at all service delivery sites. Both forms must be reprinted and placed at all service delivery sites each time the e-CHAT is updated for any reason and whenever there is a change to contact information contained in the IDF. 3. Primary and Secondary Provider Agencies must assure that the current *Health Passport* and *Physician Consultation* form			

accompany each person when taken by the provider to a medical appointment, urgent care, emergency room, or are admitted to a hospital or nursing home. (If the person is taken by a family member or guardian, the *Health Passport* and *Physician Consultation* form must be provided to them.) 4. The Physician Consultation form must be reviewed, and any orders or changes must be noted and processed as needed by the provider within 24 hours. 5. Provider Agencies must document that the *Health Passport* and *Physician Consultation* form and Advanced Healthcare Directives were delivered to the treating healthcare professional by one of the following means: a. document delivery using the *Appointments Results* section in *Therap Health Tracking Appointments*; and b. scan the signed *Physician Consultation Form* and any provided follow-up documentation into Therap after the person returns from the healthcare visit. **Chapter 13 Nursing Services: 13.2.3 General Requirements Related to Orders, Implementation, and Oversight** 1. Each person has a licensed primary care practitioner and receives an annual physical examination, dental care and specialized medical/behavioral care as needed. PPN communicate with providers regarding the person as needed. 2. Orders from licensed healthcare providers are implemented promptly and carried out until discontinued. a. The nurse will contact the ordering or on call practitioner as soon as possible, or within three business days, if the order cannot be implemented due to the person's or guardian's refusal or due to other issues delaying implementation of			

the order. The nurse must clearly document the issues and all attempts to resolve the problems with all involved parties. b. Based on prudent nursing practice, if a nurse determines to hold a practitioner's order, they are required to immediately document the circumstances and rationale for this decision and to notify the ordering or on call practitioner as soon as possible, but no later than the next business day. c. If the person resides with their biological family, and there are no nursing services budgeted, the family is responsible for implementation or follow up on all orders from all providers. Refer to Chapter 13.3 Adult Nursing Services.			

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 3: Safeguards: Decisions about Health Care or Other Treatment: Decision Consultation and Team Justification** **Process:** There are a variety of approaches and available resources to support decision making when desired by the person. The decision consultation and team justification processes assist participants and their health care decision makers to document their decisions. It is important for provider agencies to communicate with guardians to share with the Interdisciplinary Team (IDT) Members any medical, behavioral, or psychiatric information as part of an individual's routine medical or psychiatric care. For current forms and resources please refer to the DOH Website: https://nmhealth.org/about/ddsd/. 3.1.1 **Decision Consultation Process (DCP):** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies and Interdisciplinary Teams (IDTs) are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources 2. The Decision Consultation Process (DCP) is documented on the Decision Consultation and Team Justification Form (DC/TJF) and is used for health related issues when a person or their guardian/healthcare decision maker has concerns, needs more information about these types of issues or has decided not to follow all or part of a healthcare-related order, recommendation,	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 2 of 11 individual Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Healthcare Passport:** • Did not contain Emergency Contact Information (#2, 3) • Did not contain Guardianship/Healthcare Decision Maker (#2)	**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?)*: →	

or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT (e.g., nurses, therapists, dieticians, BSCs or PRS Risk Evaluator) or clinicians who have performed evaluations such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR); and d. recommendations made by a licensed professional through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), a Medical Emergency Response Plan (MERP) or another plan such as a Risk Management Plan (RMP) or a Behavior Crisis Intervention Plan (BCIP). **Chapter 10 Living Care Arrangements: Supported Living Requirements: 10.4.1.5.1 Monitoring and Supervision:** Supported Living Provider Agencies must: Ensure and document the following: a. The person has a Primary Care Practitioner. b. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist. c. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist.			

d. The person receives a hearing test as recommended by a licensed audiologist. e. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist. Agency activities occur as required for follow-up activities to medical appointments (e.g., treatment, visits to specialists, and changes in medication or daily routine). **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each			

person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. **20.5.4 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form generated from an e-CHAT in the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. **Chapter 13 Nursing Services: 13.1 Overview of The Nurse's Role in The DD Waiver and Larger Health Care System:** Routine medical and healthcare services are accessed through the person's Medicaid State Plan benefits and through Medicare and/or private insurance for persons who have these additional types of insurance coverage. DD			

Waiver health related services are specifically designed to support the person in the community setting and complement but may not duplicate those medical or health related services provided by the Medicaid State Plan or other insurance systems. Nurses play a pivotal role in supporting persons and their guardians or legal Health Care Decision makers within the DD Waiver and are a key link with the larger healthcare system in New Mexico. DD Waiver Nurses identify and support the person's preferences regarding health decisions; support health awareness and self-management of medications and health conditions; assess, plan, monitor and manage health related issues; provide education; and share information among the IDT members including DSP in a variety of settings, and share information with natural supports when requested by individual or guardian. Nurses also respond proactively to chronic and acute health changes and concerns, facilitating access to appropriate healthcare services. This involves communication and coordination both within and beyond the DD Waiver. DD Waiver nurses must contact and consistently collaborate with the person, guardian, IDT members, Direct Support Professionals and all medical and behavioral providers including Medical Providers or Primary Care Practitioners (physicians, nurse practitioners or physician assistants), Specialists, Dentists, and the Medicaid Managed Care Organization (MCO) Care Coordinators. **13.2.7 Documentation Requirements for all DD Waiver Nurses** **13.2.8 Electronic Nursing Assessment and Planning Process**			

13.2.8.1 Medication Administration Assessment Tool (MAAT) **13.2.8.2 Aspiration Risk Management Screening Tool (ARST)** **13.2.8.3 The Electronic Comprehensive Health Assessment Tool (e-CHAT)** **13.2.9.1 Health Care Plans (HCP)** **13.2.9.2 Medical Emergency Response Plan (MERP)**			

Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider	Standard Level Deficiency		
NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS: **A. Duty to report:** **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers. **(2)** All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:** **(1) Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse,	Based on observation, the Agency did not report suspected abuse, neglect, or exploitation**,** unexpected and natural/expected deaths; or other reportable incidents as required to the Division of Health Improvement. **During the on-site survey on January, 24 2023 2:00 PM, surveyors observed the following:** *During QMB's home visit for Individual #10, Surveyors observed plastic bags, cardboard boxes, clothes, and trash bags half full throughout the kitchen, living room and dining room floors that may cause a protentional tripping hazard. There were nits and cockroaches on the kitchen sink and countertops. There was cat feces throughout the kitchen floor and on the kitchen table. Kitchen and back living room had an odor of cat feces and rotten food. The kitchen table surface was covered with trash and prescription pill bottles*. **As a result of what was observed the following incident(s) was reported:** **Individual #10** • A State ANE Report was filed as a result of the following: On 1/24/2023 1:45 PM, an Incident report was reported to DHI.	**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?)***:** →	

neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242. **(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:** In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form. **(3) Limited provider investigation:** No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation. **(4) Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall:			

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

Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant. **(8) Non-responsible reporter:** Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation.			

Tag # 1A29 Complaints / Grievances Acknowledgement	Standard Level Deficiency		
NMAC 7.26.3.6: A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's complaint or grievance procedure Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Appendix A Client File Matrix**	Based on record review, the Agency did not provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 6 of 11 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: **Grievance/Complaint Procedure Acknowledgement:** • Not Current (#5, 6, 8, 9, 10, 11)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 1A31 Client Rights / Human Rights	Condition of Participation Level Deficiency		
NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 2 Human Rights:** Civil rights apply to everyone including all waiver participants. Everyone including family members, guardians, advocates, natural supports, and	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review the Agency did not ensure the rights of Individuals was not restricted or limited for 1 of 11 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. <u>No documentation</u> was found regarding Human Rights Approval for the following: • Buckle Boss - No evidence found of Human Rights Committee approval. (Individual #9) • Childproof lock on car doors. - No evidence found of Human Rights Committee approval. (Individual #9) • Physical Restraint (MANDT) - No evidence found of Human Rights Committee approval. (Individual #9)	**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?)*: →	

Provider Agencies have a responsibility to make sure the rights of persons receiving services are not violated. All Provider Agencies play a role in person-centered planning (PCP) and have an obligation to contribute to the planning process, always focusing on how to best support the person and protecting their human and civil rights. ***2.2*** **Home and Community Based Services (HCBS): Consumer Rights and Freedom:** People with I/DD receiving DD Waiver services, have the same basic legal, civil, and human rights and responsibilities as anyone else. Rights shall never be limited or restricted unnecessarily, without due process and the ability to challenge the decision, even if a person has a guardian. Rights should be honored within any assistance, support, and services received by the person. **Chapter 3 Safeguards: 3.3.5 Interventions Requiring HRC Review and Approval** HRCs must review any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies that include a restriction of an individual's rights; this HRC should occur prior to implementation of the strategy or strategies proposed. Categories requiring an HRC review include, but are not limited to, the following: 1. response cost (See the BBS Guidelines for Using Response Cost); 2. restitution (See BBS Guidelines for Using Restitution); 3. emergency physical restraint (EPR); 4. routine use of law enforcement as part of a BCIP; 5. routine use of emergency hospitalization procedures as part of a BCIP; 6. use of point systems; 7. use of intense, highly structured, and specialized treatment strategies, including			

levels systems with response cost or failure to earn components; 8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons; 9. use of PRN psychotropic medications; 10. use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey gloves for biting hand); 11. use of bed rails; 12. use of a device and/or monitoring system through RPST may impact the person's privacy or other rights; or 13. use of any alarms to alert staff to a person's whereabouts.			

Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	Standard Level Deficiency		

Developmental Disabilities Waiver Service Standards Eff 11/1/2021
Chapter 10 Living Care Arrangement (LCA):
10.3.7 Requirements for Each Residence:
Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence:
1. has basic utilities, i.e., gas, power, water, telephone, and internet access;
2. supports telehealth, and/ or family/friend contact on various platforms or using various devices;
3. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher;
4. has a general-purpose first aid kit;
5. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift;
6. has water temperature that does not exceed a safe temperature (110^0 F). Anyone with a history of being unsafe in or around water while bathing, grooming, etc. or with a history of at least one scalding incident will have a regulated temperature control valve or device installed in the home.
7. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP;
8. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy;
	Based on record review and / or observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 7 of 8 Living Care Arrangement residences.
	
	Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:
	
	Family Living Requirements:
	
	• Water temperature in home exceeds safe temperature (110^0 F)
	  • Water temperature in home measured 136.8^0 F (#2)
	  • Water temperature in home measured 114.4^0 F (#4)
	  • Water temperature in home measured 130.8^0 F (#5)
	  • Water temperature in home measured 133.7^0 F (#6)
	  • Water temperature in home measured 140.4^0 F (#8)
	  • Water temperature in home measured 143.2^0 F (#9)
	  • Water temperature in home measured 134.5^0 F (#10)
		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?)*: →	

9. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; 10. supports environmental modifications, remote personal support technology (RPST), and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; 11. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed; 12. has the phone number for poison control within line of site of the telephone; 13. has general household appliances, and kitchen and dining utensils; 14. has proper food storage and cleaning supplies; 15. has adequate food for three meals a day and individual preferences; and 16. has at least two bathrooms for residences with more than two residents. 17. Training in and assistance with community integration that include access to and participation in preferred activities to include providing or arranging for transportation needs or training to access public transportation. 18. Has Personal Protective Equipment available, when needed			

Tag # LS25.1 Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 10 Living Care Arrangement (LCA):** **10.2 Settings Requirements in LCAs:** All people have the right to choose where they live. Provider Agencies must facilitate individual choice and ensure that any LCA is chosen by the person and is integrated in and supports full access to the community. People should be given choices among all living options, including non-disability specific settings, such as personal homes, apartments or other rental options and shared living situations with non-disabled people. Provider Agencies should ensure people have opportunities to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS services. Provider Agencies must work to ensure the LCA meets CMS setting requirements and does not have the effect of isolating people from the broader community, especially if the service or setting is intended for group home living. This includes ensuring: **10.3.7 Requirements for Each Residence:** Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence: 1. has basic utilities, i.e., gas, power, water, telephone, and internet access; 2. supports telehealth, and/ or family/friend contact on various platforms or using various devices;	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on observation, the Agency did not ensure that each individual's residence met all requirements within the standard, which maintains a physical environment which is safe and comfortable for 1 of 8 Living Care Arrangement residences. Observation of the residence revealed the following: • Health Concerns (#10) **Family Living Requirements:** During on-site visit (1/24/2023), surveyors observed the following physical environment conditions which were not safe for the Individuals living in the residence: *During QMB' s home visit for Individual #10, Surveyors observed plastic bags, cardboard boxes, clothes, and trash bags half full throughout the kitchen, living room and dining room floors that may cause a protentional tripping hazard. There were nits and cockroaches on the kitchen sink and countertops. There was cat feces throughout the kitchen floor and on the kitchen table. Kitchen and back living room had an odor of cat feces and rotten food. The kitchen table surface was covered with trash and prescription pill bottles*.	**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?)*: →	

3. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher; 4. has a general-purpose first aid kit; 5. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift; 6. has water temperature that does not exceed a safe temperature (110^0 F). Anyone with a history of being unsafe in or around water while bathing, grooming, etc. or with a history of at least one scalding incident will have a regulated temperature control valve or device installed in the home. 7. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP; 8. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy; 9. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; 10. supports environmental modifications, remote personal support technology (RPST), and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; 11. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed; 12. has the phone number for poison control within line of site of the telephone;			

13. has general household appliances, and kitchen and dining utensils; 14. has proper food storage and cleaning supplies; 15. has adequate food for three meals a day and individual preferences; and 16. has at least two bathrooms for residences with more than two residents. 17. Training in and assistance with community integration that include access to and participation in preferred activities to include providing or arranging for transportation needs or training to access public transportation. 18. Has Personal Protective Equipment available, when needed **10.4.1.5.2 Additional Requirements for Each Supported Living Residence; 10.4.2.4 Intensive Medical Living Service (IMLS) Agency Requirements and 10.4.2.4.2 Monitoring and Supervision:** Provider Agencies shall assure proper sanitation and infection control measures (including adequate personal protective equipment) consistent with current national standards that are published by the Centers for Disease Control and Prevention. This includes: a. use of standard precautions; **b.** specific isolation or cleaning measures for specific illnesses; and/or **c.** communicable diseases policies which ensure that employees, subcontractors, and agency volunteers are not permitted to work with signs/symptoms of communicable disease or infected skin lesions until authorized to do so in writing by a qualified health professional.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag #1A12 All Services Reimbursement	**No Deficient Practices Found**		
NMAC 8.302.2 Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 21: Billing Requirements; 23.1 Recording Keeping and Documentation Requirements** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and 3. Details of the services provided. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer. 4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to	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 DDW services for 11 of 11 individuals. *Progress notes and billing records supported billing activities for the months of October, November and December 2022 for the following services:* • Family Living • Customized Community Supports		

any of the following for a period of at least six years from the payment date: a. treatment or care of any eligible recipient; b. services or goods provided to any eligible recipient; c. amounts paid by MAD on behalf of any eligible recipient; and d. any records required by MAD for the administration of Medicaid. **21.7 Billable Activities**: Specific billable activities are defined in the scope of work and service requirements for each DD Waiver service. In addition, any billable activity must also be consistent with the person's approved ISP. **21.9 Billable Units**: The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit, or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units. **21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following: 1. A day is considered 24 hours from midnight to midnight. 2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period. 3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months. **21.9.2 Requirements for Monthly Units:** For services billed in monthly units, a Provider Agency must adhere to the following: 1. A month is considered a period of 30 calendar days.			

2. Face-to-face billable services shall be provided during a month where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. **21.9.4 Requirements for 15-minute and hourly units:** For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following: 1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2. 2. Services that last in their entirety less than eight minutes cannot be billed.			

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date: May 5, 2023

To: Angela Ledesma, Executive Director

Provider: Angel Care of New Mexico, Inc.
Address: 2225 E. Griggs Ave.
State/Zip: Las Cruces, New Mexico 88001

E-mail Address: Angela@angelcarenm.net

Region: Southwest
Survey Date: January 17 - 27, 2023

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Family Living and Customized Community Supports

Survey Type: Routine

Dear Ms. Ledesma:

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.23.3.DDW.D4361.3.RTN.05.23.125