HEALTH CARE
AUTHORITY

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Niki Kozlowski, Acting Deputy Secretary
Alanna Dancis, Acting Medicaid Director

Date:	March 5, 2026
To:	Joyce M. Munoz, BSN, RN, Chief Executive Officer
Provider:	J & J Home Care, Inc.
Address:	1301 W. Grand Avenue
State/Zip:	Artesia, New Mexico 88210
E-mail Address:	joycem@jjhc.org
Region:	Southeast
Survey Dates:	January 5 - 16, 2026
Program Surveyed:	Medically Fragile Waiver (MFW)
Service(s) Surveyed:	Home Health Aide (HHA), Private Duty Nursing (PDN), Respite HHA, and Respite PDN
Survey Type:	Routine
Team Leader:	Armida Medina, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Jamie Pond, BS, Staff Manager, Division of Health Improvement/Quality Management Bureau; Wolf Krusemark, BFA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor Division of Health Improvement/Quality Management Bureau; Sally Karingada, BS, Healthcare Surveyor Supervisor Division of Health Improvement/Quality Management Bureau

Dear Ms. Joyce M. Munoz,

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

The following tags are identified as deficiencies:

- Tag # MF05 General Provider Requirements: Agency Case Files
- Tag # MF05.1 General Provider Requirements: Agency Case Files – Documentation
- Tag # MF22 Private Duty Nursing: Scope of Services – Plans / Assessments
- Tag # MF22.1 Private Duty Nursing: Scope of Services – IDT Meetings
- Tag # MF22.2 Private Duty Nursing: Training and Competency
- Tag # MF27 Home Health Aide: Agency/Individual Provider Requirements – Ongoing Training
- Tag # MF27.1 HHA and PDN: Agency/Individual Requirements – RN Supervision

- Tag # MF1A28.1 Incident Management System – Agency Personnel Training
- Tag # MF29 Home Health Aide – Reimbursement
- Tag # MF30 Respite – Home Health Aide – Reimbursement
- ~~Tag # MF32 Private Duty Nursing Reimbursement~~

Plan of Correction:

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

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

Corrective Action for Current Citation:

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

On-going Quality Assurance/Quality Improvement Processes:

- What is going to be done on an ongoing basis? (i.e. file reviews, etc.)
- How many individuals is this going to effect? (i.e. percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e. weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position within your agency)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORA, etc.)
- How is this integrated into 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@hca.nm.gov
2. **Developmental Disabilities Supports Division, Attention: Medically Fragile Waiver Program Manager**

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

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

Billing Deficiencies:

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

Attention: *Lisa Medina-Lujan*
HCA/OIG/Program Integrity Unit

1474 Rodeo Road
Santa Fe, New Mexico 87505

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

*Lisa Medina-Lujan (*Lisa.medina-lujan@hca.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 200-211
Albuquerque, NM 87110

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@hca.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,

Armida Medina

Armida Medina
Healthcare Surveyor / Team Lead
Health Care Authority / Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	January 5, 2026
Contact:	**J & J Home Care, Inc.** Joyce M. Munoz, BSN, RN, Chief Executive Officer **HCA/DHI/QMB** Armida Medina, Healthcare Surveyor / Team Lead Jamie Pond, BS, Staff Manager Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor Sally Karingada, BS, Healthcare Surveyor Supervisor
Entrance Date:	January 5, 2026
Present:	**J & J Home Care, Inc.** Joyce M. Munoz, BSN, RN, Chief Executive Officer **HCA/DHI/QMB** Armida Medina, Healthcare Surveyor / Team Lead Jamie Pond, BS, Staff Manager Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor Sally Karingada, BS, Healthcare Surveyor Supervisor
Exit Date:	January 16, 2026
Present:	**J & J Home Care, Inc.** Joyce M. Munoz, BSN, RN, Chief Executive Officer **HCA/DHI/QMB** Armida Medina, Healthcare Surveyor / Team Lead Jamie Pond, BS, Staff Manager Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Amanda Houlgin Castaneda, MPA Healthcare Surveyor Supervisor
Administrative Locations Visited:	0 *(Administrative portion of survey completed remotely)*
Total Wellness Visits Completed (Individuals Seen):	6
Total Compliance Survey Sample Size:	7 2 – Home Health Aide 1 – Private Duty Nursing 4 – Respite Home Health Aide 2 – Respite Private Duty Nursing
Total Homes Visited:	5
Participant Served Records Reviewed:	7
Participant / Family Members Interviewed:	6 *(Note: One Participant was not available during the on-site survey)*
Participant Served Not Seen:	1 *(Note: One Participant was not available during the on-site survey)*
Home Health Aide Records Reviewed:	2 *(Note: Two HHA perform dual roles as Respite HHAs)*
Home Health Aide Interviewed:	2

Respite HHA Records Reviewed:	3 *(Note: Two Respite HHA perform dual roles as HHAs)*
Respite HHA Interviewed:	3
Private Duty Nursing Records Reviewed:	2
Private Duty Nursing Interviewed:	1
Respite PDN Records Reviewed:	2
RN Supervisor Record(s) Reviewed:	1
RN Supervisor(s) Interviewed:	1
Administrative Personnel Interviewed:	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Participant Agency Case Files
- Internal Incident Management System Process and Reports
- Personnel Files – including nursing and subcontracted staff
- Staff Training Records, including staff training hours and staff competency reviews
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Licensure/Certification for Nursing
- Agency Policies and Procedures Manual

CC: Distribution List: HCA - Division of Health Improvement
HCA - Developmental Disabilities Supports Division
HCA - Medical Assistance Division

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.

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@hca.nm.gov for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your respective Regional DDSD Office.
4. Submit your POC to via email to MonicaE.valdez@hca.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 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: Informal Reconsideration of Findings – New Mexico Health Care Authority The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
3. The IRF request must include all supporting documentation or evidence.
4. If you have questions about the IRF process, email the IRF Chairperson, Valerie V. Valdez at valerie.valdez@hca.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.

Agency/Region(s): **J & J Home Care, Inc. – Southeast Region**
Program: Medically Fragile Waiver
Service: Home Health Aide (HHA), Private Duty Nursing (PDN), Respite Home Health Aide, and Respite Private Duty Nurse
Survey Type: Routine
Survey Dates: **January 5 – 16, 2026**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Record Requirements:			
TAG # MF05 General Provider Requirements: Agency Case Files			
New Mexico Health Care Authority Developmental Disabilities Supports Division Medically Fragile Waiver (MFW) Effective July 1, 2022 **GENERAL PROVIDER REQUIREMENTS** **V. PROVIDER AGENCY CASE FILE FOR THE WAIVER PARTICIPANT** All provider agencies are required to maintain at the administrative office a confidential case file for each person that includes all the following elements: a. Emergency contact information for the following individuals/entities that includes addresses and telephone numbers for each: i. Consumer ii. Primary caregiver iii. Family/relatives, guardians or conservators iv. Significant friends v. Physician vi. Case manager vii. Provider agencies viii. Pharmacy; b. Individual's health plan, if appropriate; c. Individual's current ISP; d. Progress notes and other service delivery documentation; e. A medical history which includes at least: demographic data; current and past medical	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 7 Participants. **Review of the Agency's Individual case files revealed the following items were not found, incomplete, and/or not current:** **Documentation of Guardianship / Power of Attorney:** • Not Found (#5)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

diagnoses including the cause of the medically fragile conditions and developmental disability; medical and psychiatric diagnoses; allergies (food, environmental, medications); immunizations; and most recent physical exam. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. **VI. DOCUMENTATION** A. Provider agencies must maintain all records necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to individuals who are currently receiving services. The provider agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, level of services, and length of service billed. B. The documentation of the billable time spent with an individual are kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record must contain at least the following information: a. date and start and end time of each service encounter or other billable service interval; b. description of what occurred during the encounter or service interval; and c. signature and title of staff providing the service verifying that the service and time are correct. C. All records pertaining to services provided to an individual must be maintained for at least six (6) years from the date of creation. D. Verified electronic signatures may be used. An electronic signature must be HIPAA compliant, which means the attribute affixed to an electronic document must bind to a particular party. An electronic signature secures			

the user authentication, proof of claimed identity, at the time the signature is generated. It also creates the logical manifestation of signature, including the possibility for multiple parties to sign a document and have the order of application recognized and proven. In addition, it supplies additional information such as time stamp and signature purpose specific to that user and ensures the integrity of the signed document to enable transportability of data, independent verifiability and continuity of signature capability. If an entity uses electronic signatures, the signature method must assure that the signature is attributable to a specific person and binding of the signature with each particular document. **NMAC 8.370.22.34 PATIENT/CLIENT RECORDS:** Each agency licensed pursuant to these regulations must maintain the original record for each patient/client receiving services. Patient/client records shall be made available for review upon request of the licensing authority. Every record must be accurate, legible, promptly completed and consistently organized. A patient/client record must meet the following criteria: A. Content of patient/client record: (1) Medically directed patient/client record must include: (a) past and current medical findings in accordance with accepted professional standard; (b) plan of care; (c) identifying information; (d) name of physician; (e) medications, diet, treatment/services, and activity orders; (f) signed and dated notes on the day service(s) provided;			

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

TAG # MF05.1 General Provider Requirements: Agency Case Files – Documentation			
New Mexico Health Care Authority Developmental Disabilities Supports Division Medically Fragile Waiver (MFW) Effective July 1, 2022 **GENERAL PROVIDER REQUIREMENTS** **V. PROVIDER AGENCY CASE FILE FOR THE WAIVER PARTICIPANT** All provider agencies are required to maintain at the administrative office a confidential case file for each person that includes all the following elements: d. Progress notes and other service delivery documentation; **VI. DOCUMENTATION** A. Provider agencies must maintain all records necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to individuals who are currently receiving services. The provider agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, level of services, and length of service billed. B. The documentation of the billable time spent with an individual are kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record must contain at least the following information: a. date and start and end time of each service encounter or other billable service interval; b. description of what occurred during the encounter or service interval; and c. signature and title of staff providing the service verifying that the service and time are correct.	Based on record review, the Agency did not maintain the complete required documentation necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to Participants who are currently receiving services in the Agency's Case File for 3 of 7 Participants. **Review of the Agency's Individual case files revealed the following items were not found, incomplete, and/or not current:** **Private Duty Nursing Progress Notes:** • **Individual #4** – None found for 9/2/2025. **Respite Home Health Aide Progress Notes:** • **Individual #1** – None found for 11/18/2025. • **Individual #10** – None found for 10/20 & 24, 2025, and 11/7 & 14, 2025.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

C. All records pertaining to services provided to an individual must be maintained for at least six (6) years from the date of creation. D. Verified electronic signatures may be used. An electronic signature must be HIPAA compliant, which means the attribute affixed to an electronic document must bind to a particular party. An electronic signature secures the user authentication, proof of claimed identity, at the time the signature is generated. It also creates the logical manifestation of signature, including the possibility for multiple parties to sign a document and have the order of application recognized and proven. In addition, it supplies additional information such as time stamp and signature purpose specific to that user and ensures the integrity of the signed document to enable transportability of data, independent verifiability and continuity of signature capability. If an entity uses electronic signatures, the signature method must assure that the signature is attributable to a specific person and binding of the signature with each particular document. **PRIVATE DUTY NURSING:** **III. ADMINISTRATIVE REQUIREMENTS** **B. Documentation Requirements:** 1. Documentation is required to be completed in accordance with applicable MFW Standards, Federal HH Agency (42 CFR 484) regulations, or State HH Agency licensing (7.28.2 NMAC). 7. Progress notes must include dates, number, and types of treatments performed, participant's response to treatment, and progress toward therapy goals using the parameters identified in the initial and annual treatment plan and/or evaluation. **RESPITE STANDARDS:** **II. IN-HOME RESPITE**			

B. Agency Provider Requirement 1. The agency is responsible to ensure that the direct support professionals (RN, LPN, and HHA) meet all applicable MFW, State and Federal requirements for PDN and HHA. 5. A log of respite hours used must be established and maintained. **NMAC 8.370.22.34 PATIENT/CLIENT RECORDS:** Each agency licensed pursuant to these regulations must maintain the original record for each patient/client receiving services. Patient/client records shall be made available for review upon request of the licensing authority. Every record must be accurate, legible, promptly completed and consistently organized. A patient/client record must meet the following criteria: A. Content of patient/client record: …. (f) signed and dated notes on the day service(s) provided; (c) signed and dated notes on the day service(s) provided			

TAG # MF22 Private Duty Nursing: Scope of Services – Plans / Assessments			
New Mexico Health Care Authority Developmental Disabilities Supports Division Medically Fragile Waiver (MFW) Effective July 1, 2022 **PRIVATE DUTY NURSING** **I. SCOPE OF SERVICE** **B. Private Duty Nursing Services Include:** 1. The private duty nurse provides nursing services in accordance with the New Mexico Nursing Practice Act, Chapter 61, and Article 3 NMSA 1978. 2. The private duty nurse develops, implements, evaluates and coordinates the medically fragile participant's plan of care on a continuing basis. This plan of care may require coordination with multiple agencies. A copy of the plan of care must be maintained in the participant's home. 3. The private duty nurse provides the participant, caregiver, and family all training and education pertinent to the treatment plan and equipment used by the participant. 4. The private duty nurse must meet the documentation requirements of the MFW, Federal and State HH Agency licensing regulations and all policies and procedures of the HH Agency where the nurse is employed. All documentation must include dates and types of treatments performed; as well as person's response to treatment and progress towards all goals. 5. The private duty nurse must follow the National HH Agency regulations (42 CFR 484) and state HH Agency licensing regulation (7.28.2 NMAC) that apply to PDN services. 6. The private duty nurse implements the Physician/Healthcare Practitioner orders.	Based on record review, the Agency did not ensure that the HH Agency's RN Supervisor or RN designee nursing scope of services documentation was complete for 1 of 7 Participants. **CMS-485 not reviewed by RN Supervisor or RN designee at least every 60 days as required for the following:** • **Individual #9** – CMS-485 reviewed by RN Supervisor or RN designee on 2/7/2025; next certification period not reviewed until 10/11/2025 for certification period covering 3/30/2025 – 8/11/2025.	**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?)*: →	

7. The standardized CMS-485 (Home Health Certification and Plan of Care) form will be reviewed by the RN supervisor or RN designee and renewed by the PCP at least every sixty (60) days. 8. The private duty nurse administers Physician/Healthcare Practitioner ordered medication as prescribed utilizing all Federal, State, and MFW regulations and following HH Agency policies and procedures. This includes all ordered medication routes including oral, infusion, therapy, subcutaneous, intramuscular, feeding tubes, sublingual, topical, and inhalation therapy. 9. Medication profiles must be maintained for each participant with the original kept at the HH Agency and a copy in the home. The medication profile will be reviewed by the licensed HH Agency RN supervisor or RN designee at least every sixty (60) days. 10. The private duty nurse is responsible for checking and knowing the following regarding medications: a. Medication changes, discontinued medication, and new medication, and will communicate changes to all pertinent providers, primary care giver and family; b. Response to medication; c. Reason for medication; d. Adverse reactions; e. Significant side effects; f. Drug allergies; and g. Contraindications 11. The private duty nurse must follow the HH Agency's policy and procedure for management of medication errors. 12. The private duty nurse providing direct care to a medically fragile participant will be oriented to the unique needs of the participant by the family, HH Agency and other resources as			

needed, prior to the nurse providing independent services. 13. The private duty nurse develops and maintains skills to safely manage all devices and equipment needed in providing care for the participant. 14. The private duty nurse monitors all equipment for safe functioning and facilitates maintenance and repair as needed. 15. The private duty nurse will obtain pertinent medical history. 16. The private duty nurse will be responsible for the following: a. Obtaining pertinent medical history; b. Assisting in the development and implementation of bowel and bladder regimens and monitor such regimens and modify as needed. This includes removal of fecal impactions and bowel and/or bladder training, urinary catheter and supra-public catheter care; c. Assisting with the development, implementation, modification, and monitoring of nutritional needs via feeding tubes and orally per Physician/Healthcare Practitioner order and within the nursing scope of practice; d. Providing ostomy care per Physician/Healthcare Practitioner order; e. Monitoring respiratory status and treatments including the participant's response to therapy; f. Providing rehabilitative nursing; g. Collecting specimens and obtaining cultures per Physician/Healthcare Practitioner order; h. Providing routine assessment, implementation, modification, and monitoring of skin condition and wounds; i. Providing routine assessment, implementation, modification, and monitoring of Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL); j. Monitoring vital signs per Physician/Healthcare Practitioner orders or per			

HH Agency policy. 17. The private duty nurse must consult and collaborate with the participant's PCP, specialists, other team members, and primary care giver/family, for the purpose of evaluation of the participant and/or developing, modifying, or monitoring services and treatment. This collaboration with team members will include, but will not be limited to, the following: a. Analyzing and interpreting the person's needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings; b. Identifying short and long-terms goals that are measurable and objective. The goals should include interventions to achieve and promote health that is related to the participant's needs. 18. The individualized service goals and a nursing care plan will be separate from the CMS-485. The nursing plan of care is based on the Physician/Healthcare Practitioner treatment plan and the medically fragile participant's and family's concerns and priorities as identified in the ISP. The identified goals and outcomes in the ISP will be specifically addressed in the nursing plan of care. 19. The private duty nurse must review Physician/Healthcare Practitioner orders for treatment. If changes in the treatment require revisions to the ISP, the agency nurse will contact the CM to request an Interdisciplinary Team (IDT) meeting. 20. The private duty nurse coordinates with the CM all services that may be provided in the home and community setting. 21. PDN services may be provided in the home or other community setting. 22. The private duty nurse may ride in the vehicle with the person for the purpose of oversight, support, or monitoring during			

transportation. The private duty nurse may not operate the vehicle for the purpose of transporting the participant. **RESPITE STANDARDS** **II. IN-HOME RESPITE** B. Agency Provider Requirement 1. The agency is responsible to ensure that the direct support professionals (RN, LPN, and HHA) meet all applicable MFW, State and Federal requirements for PDN and HHA. 2. The agency will follow the MFW PDN and HHA Standards. 3. Respite services must be provided by qualified personnel as delineated in the agency's licensure requirements and follow the MFW Standards and the MFW Provider Agreement. 4. Advance notice to the CM is required. This includes a timeline from the person/person's representative. 5. A log of respite hours used must be established and maintained. 6. The CM must complete and approve required paperwork for the agency's respite services prior to implementation. 7. All services provided during respite must be documented following the documentation standards by the MFW, State, Federal and agency requirements. 8. The agency personnel must be culturally sensitive to the needs and preferences of person and members of their household. Arrangement of written or spoken communication in another language may need to be considered.			

TAG # MF22.1 Private Duty Nursing: Scope of Services – IDT Meetings			
New Mexico Health Care Authority Developmental Disabilities Supports Division Medically Fragile Waiver (MFW) Effective July 1, 2022 **PRIVATE DUTY NURSING:** **I. SCOPE OF SERVICE** **D. Attendance at the IDT Meeting:** 1. The HH Agency's RN supervisor is the HH Agency's representative at the IDT meeting. An alternative RN may represent the agency at the IDT meeting if the supervising nurse is unable to attend in person or by conference call. 2. If unable to attend the IDT meeting, the nurse is expected to submit recommended updates to the strategies, nursing plan of care, goals, and objectives in advance of the meeting for the team's consideration. The nurse and CM will follow up after the IDT meeting to update the nurse on decisions and specific issues. 3. The agency nurse or designee must document in the participant's HH Agency file the date, time, and coordination of any changes to strategies, nursing care plans, goals, and objectives as a result of the IDT meeting. 4. Only one nurse representative per agency or discipline will be reimbursed for the time at the IDT meeting. The agency nurse representative must attend physically or telephonically in order to be reimbursed. 5. The HH Agency nurse is responsible for signing the IDT sign-in sheet. 6. Annually, and as needed, the agency RN may need to assist the CM with justification documentation supporting the modification to the approved budget (MAD 046 form). 7. PDN services do not start until there is an approved MAD 046 form for nursing.	Based on record review, the Agency did not ensure that the HH Agency's RN Supervisor or RN designee attended the IDT meeting as required by standard for 2 of 7 Participants. **Review of the Agency's Participant case files found no evidence of the attendance or participation in the ISP meeting:** • Not Found (#1, 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?)*: →	

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

TAG # MF22.2 Private Duty Nursing: Training and Competency			
New Mexico Health Care Authority Developmental Disabilities Supports Division Medically Fragile Waiver (MFW) Effective July 1, 2022 **PRIVATE DUTY NURSING** **I. SCOPE OF SERVICE** **B. Private Duty Nursing Services Include:** 1. The private duty nurse provides nursing services in accordance with the New Mexico Nursing Practice Act, Chapter 61, and Article 3 NMSA 1978. 2. The private duty nurse develops, implements, evaluates and coordinates the medically fragile participant's plan of care on a continuing basis. This plan of care may require coordination with multiple agencies. A copy of the plan of care must be maintained in the participant's home. 3. The private duty nurse provides the participant, caregiver, and family all training and education pertinent to the treatment plan and equipment used by the participant. 4. The private duty nurse must meet the documentation requirements of the MFW, Federal and State HH Agency licensing regulations and all policies and procedures of the HH Agency where the nurse is employed. All documentation must include dates and types of treatments performed; as well as person's response to treatment and progress towards all goals. 5. The private duty nurse must follow the National HH Agency regulations (42 CFR 484) and state HH Agency licensing regulation (7.28.2 NMAC) that apply to PDN services. 6. The private duty nurse implements the Physician/Healthcare Practitioner orders.	Based on interview, the Agency did not ensure training competencies for 3 of 6 Private Duty Nurses. **When the Agency's Private Duty Nurse was asked, do you provide transportation for the Participant:** • PDN #506 stated, "Mostly as her grandma, but I do sometimes as paid service too." (Participant #4) • PDN #505 stated, "Yes sir, we purchased a handicap van with a wheelchair lift. I transport her constantly, off duty and on whenever she requires." (Participant #5) • PDN #503 stated, "I have, yes." (Participant #9) Per the Medically Fragile Waiver standards, Private Duty Nursing section B.22, "The private duty nurse may ride in the vehicle with the person for the purpose of oversight, support, or monitoring during transportation. The private duty nurse may not operate the vehicle for the purpose of transporting the participant."	**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?)*: →	

7. The standardized CMS-485 (Home Health Certification and Plan of Care) form will be reviewed by the RN supervisor or RN designee and renewed by the PCP at least every sixty (60) days. 8. The private duty nurse administers Physician/Healthcare Practitioner ordered medication as prescribed utilizing all Federal, State, and MFW regulations and following HH Agency policies and procedures. This includes all ordered medication routes including oral, infusion, therapy, subcutaneous, intramuscular, feeding tubes, sublingual, topical, and inhalation therapy. 9. Medication profiles must be maintained for each participant with the original kept at the HH Agency and a copy in the home. The medication profile will be reviewed by the licensed HH Agency RN supervisor or RN designee at least every sixty (60) days. 10. The private duty nurse is responsible for checking and knowing the following regarding medications: a. Medication changes, discontinued medication, and new medication, and will communicate changes to all pertinent providers, primary care giver and family; b. Response to medication; c. Reason for medication; d. Adverse reactions; e. Significant side effects; f. Drug allergies; and g. Contraindications 11. The private duty nurse must follow the HH Agency's policy and procedure for management of medication errors. 12. The private duty nurse providing direct care to a medically fragile participant will be oriented to the unique needs of the participant by the family, HH Agency and other resources as			

needed, prior to the nurse providing independent services. 13. The private duty nurse develops and maintains skills to safely manage all devices and equipment needed in providing care for the participant. 14. The private duty nurse monitors all equipment for safe functioning and facilitates maintenance and repair as needed. 15. The private duty nurse will obtain pertinent medical history. 16. The private duty nurse will be responsible for the following: a. Obtaining pertinent medical history; b. Assisting in the development and implementation of bowel and bladder regimens and monitor such regimens and modify as needed. This includes removal of fecal impactions and bowel and/or bladder training, urinary catheter and supra-public catheter care; c. Assisting with the development, implementation, modification, and monitoring of nutritional needs via feeding tubes and orally per Physician/Healthcare Practitioner order and within the nursing scope of practice; d. Providing ostomy care per Physician/Healthcare Practitioner order; e. Monitoring respiratory status and treatments including the participant's response to therapy; f. Providing rehabilitative nursing; g. Collecting specimens and obtaining cultures per Physician/Healthcare Practitioner order; h. Providing routine assessment, implementation, modification, and monitoring of skin condition and wounds; i. Providing routine assessment, implementation, modification, and monitoring of Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL); j. Monitoring vital signs per Physician/Healthcare Practitioner orders or per			

HH Agency policy. 17. The private duty nurse must consult and collaborate with the participant's PCP, specialists, other team members, and primary care giver/family, for the purpose of evaluation of the participant and/or developing, modifying, or monitoring services and treatment. This collaboration with team members will include, but will not be limited to, the following: a. Analyzing and interpreting the person's needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings; b. Identifying short and long-terms goals that are measurable and objective. The goals should include interventions to achieve and promote health that is related to the participant's needs. 18. The individualized service goals and a nursing care plan will be separate from the CMS-485. The nursing plan of care is based on the Physician/Healthcare Practitioner treatment plan and the medically fragile participant's and family's concerns and priorities as identified in the ISP. The identified goals and outcomes in the ISP will be specifically addressed in the nursing plan of care. 19. The private duty nurse must review Physician/Healthcare Practitioner orders for treatment. If changes in the treatment require revisions to the ISP, the agency nurse will contact the CM to request an Interdisciplinary Team (IDT) meeting. 20. The private duty nurse coordinates with the CM all services that may be provided in the home and community setting. 21. PDN services may be provided in the home or other community setting. 22. The private duty nurse may ride in the vehicle with the person for the purpose of oversight, support, or monitoring during			

transportation. The private duty nurse may not operate the vehicle for the purpose of transporting the participant.			

TAG # MF27 Home Health Aide: Agency/Individual Provider Requirements – Ongoing Training			
New Mexico Health Care Authority Developmental Disabilities Supports Division Medically Fragile Waiver (MFW) Effective July 1, 2022 **GENERAL PROVIDER REQUIREMENTS** **I. PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Health Care Authority (DOH) and the HSD. **HOME HEALTH AIDE (HHA)** **I. SCOPE OF SERVICES** C. Home Health Aide will not: 1. Administer medications or tube feedings, 2. Adjust oxygen levels, 3. Perform any intravenous procedures, 4. Perform any sterile procedures, 5. Perform housekeeping services for members of the medically fragile person's family. **II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS** A. The HH Agency must be a current MFW provider with the Provider Enrollment Unit (PEU)/Developmental Disabilities Supports Division (DDSD). B. HHA Qualifications: 1. HHA Certificate from an approved community-based program following the HHA training Federal regulations 42 CFR 484.36 or the State Regulation 7 NMAC 28.2., or; 2. HHA training at the licensed HH Agency which follows the Federal HHA training	Based on record review and interview(s), the Agency did not ensure Orientation and ongoing Training requirements were met for 2 of 3 Agency Personnel. **When HHA Agency Personnel were asked, are there duties which you are not allowed to perform, the following was reported:** • HHA #500 stated, "I do specifically what I do for her only, like bathe her, dress her, give her medication." • HHA #502 stated, "I honestly don't know." Per the Medically Fragile Waiver standards, Home Health Aide (HHA) I. Scope of Services C. "Home Health Aide will not: 1. Administer medications or tube feedings, 2. Adjust oxygen levels, 3. Perform any intravenous procedures, 4. Perform any sterile procedures, 5. Perform housekeeping services for members of the medically fragile person's family."	**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?)*: →	

regulation in 42 CFR 484.36 or the State Regulation 7 NMAC 28.2., or; 3. A Certified Nurses' Assistant (CNA) who has successfully completed the employing HH Agency's written and practical competency standards and meets the qualifications for an HHA with the MFW. Documentation will be maintained in personnel file. 4. A HHA who was not trained at the employing HH Agency will need to successfully complete the employing HH Agency's written and practical competency standards before providing direct care services. Documentation will be maintained in personnel file. 5. The HHA will be supervised by the HH Agency RN supervisor or HH Agency RN designee at least once every 60 days in the participant's home. 6. The HHA will be culturally sensitive to the needs and preferences of the participants and their families. Based upon the individual language needs or preferences, HHA may be requested to communicate in a language other than English. **III. ADMINISTRATIVE REQUIREMENTS** The administrative requirements are directed at the HH Agency, Rural Health Clinic or Licensed or Certified Federally Qualified Health Center. A. The HH Agency will maintain licensure as a HH Agency, Rural Health Clinic or Federally Qualified Health Center, or maintain certification as a Federally Qualified Health Center. B. The HH Agency will assure that HHA services are delivered by an employee meeting the educational, experiential and training requirements as specified in the Federal 42 CFT 484.36 or State 7 NMAC 28.2.			

C. Copies of CNA certificates must be requested by the employer and maintained in the personnel file of the HHA. D. The HH Agency will implement HHA care activities/plan of care per the participant's ISP identified strengths, concerns, priorities and outcomes. E. A HH Agency may consider hiring a participant's family member to provide HHA services if no other staff are available. The intent of the HHA service is to provide support to the family, and extended family should not circumvent the natural family support system. F. A participant's spouse or parent, if the participant is a minor child, cannot be considered as a HHA. G. The HHA is not a primary care giver, therefore when the HHA is on duty; there must be an approved primary caregiver available in person. The participant and/or representative and agency have the responsibility to assure there is a primary caretaker available in person. The primary caregiver or a responsible adult must be available on the property where the participant is currently located and within audible range of the participant and HHA. **<u>NMAC 8.370.22.30</u> HOME HEALTH AIDE TRAINING REQUIREMENTS:** **A. General:** No agency licensed pursuant to these regulations may employ an individual as a home health aide on a full-time, part-time, temporary, per diem, or other basis unless: **(1)** that individual is competent to provide services as a home health aide; **(2)** that individual has completed a training program or a competency evaluation program as outlined in these regulations. **C. Course requirements:** Home health aides: The home health aide training program must address each of the subject areas listed below			

through classroom and supervised practical training totaling at least 75 hours, with at least 16 hours devoted to supervised practical training. "Supervised practical training" means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or licensed practical nurse. **(1)** the individual being trained must complete at least 16 hours of classroom training before beginning the supervised practical training; **(2)** communications skills; **(3)** observation, reporting and documentation of patient status and the care or service furnished; **(4)** reading and recording of vital signs; **(5)** basic infection control procedures; **(6)** basic elements of body functioning and changes in body function that must be reported to an aide's supervisor; **(7)** maintenance of a clean, safe and healthy environment; **(8)** recognizing emergencies and knowledge of emergency procedures (including CPR and first aid); **(9)** the physical, emotional and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, his or her privacy and his or her property; **(10)** appropriate and safe techniques in personal hygiene and grooming that include, but are not limited to, bathing, shampooing, nail and skin care, oral hygiene and toileting; **(11)** safe transfer techniques and ambulation; **(12)** normal range of motion and positioning; **(13)** nutrition and hydration; **(14)** patient/client rights, including respect for cultural diversity;			

(15) any other task that the home health agency may choose to have the home health aide perform. **NMAC 8.370.22.30** **F. Annual in-service training:** Each home health aide must participate in at least 12 documented hours of in-service training during each 12 month period. This requirement may be fulfilled on a prorated basis during the home health aide's first year of employment at the home health agency.			

TAG # MF27.1 HHA and PDN: Agency/Individual Requirements – RN Supervision			
New Mexico Health Care Authority Developmental Disabilities Supports Division Medically Fragile Waiver (MFW) Effective July 1, 2022 **<u>HOME HEALTH AIDE (HHA)</u>** **II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS** A. The HH Agency must be a current MFW provider with the Provider Enrollment Unit (PEU)/Developmental Disabilities Supports Division (DDSD). **B. HHA Qualifications:** 1. HHA Certificate from an approved community-based program following the HHA training Federal regulations 42 CFR 484.36 or the State Regulation 7 NMAC 28.2., or; 2. HHA training at the licensed HH Agency which follows the Federal HHA training regulation in 42 CFR 484.36 or the State Regulation 7 NMAC 28.2., or; 3. A Certified Nurses' Assistant (CNA) who has successfully completed the employing HH Agency's written and practical competency standards and meets the qualifications for a HHA with the MFW. Documentation will be maintained in personnel file. 4. A HHA who was not trained at the employing HH Agency will need to successfully complete the employing HH Agency's written and practical competency standards before providing direct care services. Documentation will be maintained in personnel file. 5. The HHA will be supervised by the HH Agency RN supervisor or HH Agency RN designee at least once every 60 days in the participant's home.	Based on record review, the Agency did not ensure complete documentation that the Home Health Aide and/or Private Duty Nurse were supervised by the Agency's RN Supervisor as required for 1 of 7 Participants. **Review of the Agency's Individual case files revealed no evidence of the RN supervisory visits with the Home Health Aide for:** • **Individual #6** – Not found for 7/2025, and 9/2025. **Review of the Agency's Individual case files revealed RN supervisory visits with the Home Health Aide did not contain all required elements for the following:** • **Individual #6** – The following elements were not found for 11/3/2025**:** ➢ Review of HHA plan of care with appropriate modification annually and as needed.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

6. The HHA will be culturally sensitive to the needs and preferences of the participants and their families. Based upon the individual language needs or preferences, HHA may be requested to communicate in a language other than English. C. All supervisory visits/contacts must be documented in the participant's HH Agency clinical file on a standardized form that reflects the following: 1. Service received; 2. Participant's status; 3. Contact with family members; 4. Review of HHA plan of care with appropriate modification annually and as needed. D. Requirements for the HH Agency Serving Medically Fragile Waiver Population: 1. The HH Agency nursing supervisors(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN and HHA. 2. The HH Agency staff will be culturally sensitive to the needs and preferences of participants and households. Arrangement of written or spoken communication in another language must be considered. 3. The HH Agency will document and report any noncompliance with the ISP to the case manager. 4. All Physician orders that change the participant's service needs should be conveyed to the CM for coordination with service providers and modification to ISP/MAD 046 if necessary. 5. The HH Agency will document in the participant's clinical file that the RN supervision of the HHA occurs at least once every sixty days. Supervisory forms must be developed and implemented specifically for this task. 6. The HH Agency and CM must have documented monthly contact that reflects the			

discussion and review of services and ongoing coordination of care. 7. The HH Agency supervising RN, direct care RN and LPN trains families, direct support professionals and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments, use of equipment and technologies or other areas of concern. 8. It is expected the HH Agency will consult with, Interdisciplinary Team (IDT) members, guardians, family, and direct support professionals (DSP) as needed. **PRIVATE DUTY NURSING** **II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS** **E. Requirements for the HH Agency Serving the Medically Fragile Waiver Population:** 1. A RN or LPN in the state of New Mexico must maintain current licensure as required by the state of New Mexico Board of Nursing. The HH Agency will maintain verification of current licensure. Nursing experience in the area of developmental disabilities and/or medically fragile conditions is preferred. 2. When the HH Agency deems the nursing applicant's experience does not meet MFW Standards, then the applicant can be considered for employment by the agency if he/she completes an approved internship or similar program. The program must be approved by the MFW Manager and Human Services Department (HSD) representative. 3. The supervision of all HH Agency personnel is the responsibility of the HH Agency Administrator or Director. 4. The HH Agency Nursing Supervisors(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN, and Home Health Aide (HHA).			

5. The HH Agency staff will be culturally sensitive to the needs and preferences of participant, participant representative and households. Arrangement of written or spoken communication in another language must be considered. 6. The HH Agency will document and report any noncompliance with the ISP to the CM. 7. All Physician/Healthcare Practitioner orders that change the person's LOC will be conveyed to the CM for coordination with service providers and modification to the ISP/budget if necessary. 8. The HH Agency must document in the participant's clinical file RN supervision to occur at least every sixty (60) days. Supervisory forms must be developed and implemented specifically for this task. 9. The HH Agency and CM must have documented monthly contact that reflects the discussion and review of services and ongoing coordination of care. 10. The HH Agency supervising RN, direct care RN, and LPN trains the participant, family, direct support professional (DSP) and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments, use of equipment and technologies, or other areas of concern. 11. It is expected that the HH Agency will consult with the participant, IDT members, guardians, family, and DSP as needed. **NMAC 7.28.2.29 SUPERVISION OF SECONDARY AND NONLICENSED PERSONNEL:** **A. Licensed practical nurses:** Services and care provided by a licensed practical nurse will be furnished under the supervision of a registered nurse who has a minimum of one			

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

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Agency Personnel Requirements:			
TAG # MF1A28.1 Incident Management System – Agency Personnel Training			
New Mexico Health Care Authority Developmental Disabilities Supports Division Medically Fragile Waiver (MFW) Effective July 1, 2022 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **I. PROVIDER REQUIREMENTS** A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Health Care Authority (DOH) and the HSD. C. All providers must be currently enrolled as a MFW provider through the Developmental Disabilities Supports Division (DDSD) Provider Enrollment Unit process: a. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures. b. All provider agencies that enter a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies and standards. c. Reference: http://dhi.health.state.nm.us/ D. All agencies must follow all applicable DDSD Policies and Procedures. **<u>NMAC 8.370.10.8</u> INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** A. Duty to report:	Based on record review and interview(s), the Agency did not ensure the HCA DDSD Incident Management Abuse, Neglect, and Exploitation Training for 1 of 8 Agency Personnel. **The following Agency Personnel record(s) contained no evidence of the annual New Mexico HCA DDSD Abuse Neglect and Exploitation training was completed for the following:** • Not Found: #506	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

(1) 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 Health Care Authority improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident… **NMAC 8.370.10.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **B. Training curriculum:** Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in			

Subsection A of 8.370.10.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 8.370.10.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer. **C. Incident management system training curriculum requirements:** **(1)** The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to: **(a)** an overview of the potential risk of abuse, neglect, or exploitation; **(b)** informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths; **(d)** specific instructions on how to respond to abuse, neglect, or exploitation; **(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury. **(2)** All current employees and volunteers shall receive training within 90 days of the effective date of this rule. **(3)** All new employees and volunteers shall receive training prior to providing services to consumers.			

D. Training documentation: All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Medicaid Billing/Reimbursement			
TAG # MF29 Home Health Aide – Reimbursement *(Correction)*			
New Mexico Health Care Authority Developmental Disabilities Supports Division Medically Fragile Waiver (MFW) Effective July 1, 2022 **<u>GENERAL PROVIDER REQUIREMENTS</u>** **VI. DOCUMENTATION** A. Provider agencies must maintain all records necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to individuals who are currently receiving services. The provider agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, level of services, and length of service billed. B. The documentation of the billable time spent with an individual are kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record must contain at least the following information: a. date and start and end time of each service encounter or other billable service interval; b. description of what occurred during the encounter or service interval; and c. signature and title of staff providing the service verifying that the service and time are correct. **HOME HEALTH AIDE (HHA)** **IV. REIMBURSEMENT:** Each provider of a service is responsible for providing clinical documentation that identifies direct care professional (DCP) roles in all	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Home Health Aide services for 2 of 2 Individuals. **Individual #1:** September 2026 • Agency billed 8 units of Home Health Aide Services (S9122) on 9/1/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 9/15/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/2/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 9/15/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

components of the provision of home care, including assessment information, care planning, intervention, communications, and care coordination and evaluation. There must be justification in each participant's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant's representative and other caregivers as applicable. All services provided, claimed and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget. A. Payment for HHA services through the Medicaid Waiver is considered payment in full. B. The HHA services must abide by all Federal, State, HSD and DOH policies and procedures regarding billable and non-billable items. C. The billed services must not exceed capped dollar amount for LOC. D. The HHA services are a Medicaid benefit for children birth to 21 years through the children's EPSDT program. E. The Medicaid benefit is the payer of last resort. Payment for HHA services should not be requested until all other third party and community resources have been explored and/or exhausted. F. Reimbursement for HHA services will be based on the current rate allowed for the services. G. The HH Agency must follow all current billing requirements by the HSD and the DOH for HHA services. H. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.	• Agency billed 8 units hours of Home Health Aide Services (S9122) on 9/3/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 9/15/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/4/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 9/15/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 7.5 units of Home Health Aide Services (S9122) on 9/5/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 9/15/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 7.5 units of Home Health Aide Services (S9122) on 9/8/2025.		

I. Providers of service have the responsibility to review and assure that the information on the MAD 046 for their services is current. If the provider identifies an error, they will contact the CM or a supervisor at the case management agency immediately to have the error corrected. J. The MFW Program does not consider the following to be professional HHA duties and will not authorize payment for: 1. Performing errands for the participant/participant's representative or family that is not program specific; 2. "Friendly visiting", meaning visits with participant outside of work scheduled. 3. Financial brokerage services, handling of participant finances or preparation of legal documents; 4. Time spent on paperwork or travel that is administrative for the provider; 5. Transportation of participants without agency approval; 6. Pick up and/or delivery of commodities; and 7. Other non-Medicaid reimbursable activities. **NMAC 8.314.3.17 Reimbursement:** Waiver service providers must submit claims for reimbursement to MAD's fiscal contractor for processing. Claims must be filed per the billing manual. Providers instructions in the Medicaid policy must follow all Medicaid billing instructions. See Section 8.302.2 NMAC. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to providers of Medicaid waiver services is made at a predetermined reimbursement rate. [8.314.3.17 NMAC - Rp, 8 .314.3.17 NMAC, 3/1/2018]	Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 9/29/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/9/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 9/29/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/10/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 9/29/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/11/2025. Documentation accounted for 0 hours.		

	Documentation on the following date were created after billing took place. ➢ Per the 9/29/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/12/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 9/29/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/15/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/16/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place.		

	➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/22/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/23/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units hours of Home Health Aide Services (S9122) on 9/24/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place.		

	➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/25/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 7 units of Home Health Aide Services (S9122) on 9/26/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/13/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/29/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/13/2025 Remittance Advice (RA), the agency was paid for the		

	above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/30/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/13/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/1/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/13/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units hours of Home Health Aide Services (S9122) on 10/2/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/13/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it		

	was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/3/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/13/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 7.75 units of Home Health Aide Services (S9122) on 10/6/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/20/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/7/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/20/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid.		

	• Agency billed 8 units of Home Health Aide Services (S9122) on 10/8/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/20/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/9/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/20/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 6.25 units of Home Health Aide Services (S9122) on 10/10/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/20/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid.		

	• Agency billed 8 units of Home Health Aide Services (S9122) on 10/13/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/27/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 7 units of Home Health Aide Services (S9122) on 10/14/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/27/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 5 units of Home Health Aide Services (S9122) on 10/15/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/27/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 4 units of Home Health Aide Services (S9122) on 10/16/2025.		

	Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/27/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 5 units of Home Health Aide Services (S9122) on 10/17/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/27/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 7 units hours of Home Health Aide Services (S9122) on 10/20/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/21/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 6 units of Home Health Aide Services (S9122) on 10/21/2025. Documentation accounted for 0 hours.		

	Documentation on the following date were created after billing took place. ➢ Per the 10/21/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 7 units of Home Health Aide Services (S9122) on 10/22/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/21/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 4.75 units of Home Health Aide Services (S9122) on 10/23/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 10/21/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 5 units of Home Health Aide Services (S9122) on 10/24/2025. Description of services were created after billing took place.		

	➢ Per the 10/21/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 6 units of Home Health Aide Services (S9122) on 10/27/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/10/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 7 units of Home Health Aide Services (S9122) on 10/28/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/10/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 7 units of Home Health Aide Services (S9122) on 10/29/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/10/2025 Remittance Advice (RA), the agency was paid for the		

	above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 5 units of Home Health Aide Services (S9122) on 10/30/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/10/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 5 units of Home Health Aide Services (S9122) on 10/31/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/10/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 6.5 units of Home Health Aide Services (S9122) on 11/3/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/17/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it		

	was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 6 units of Home Health Aide Services (S9122) on 11/4/2026. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/17/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 6.75 units of Home Health Aide Services (S9122) on 11/5/2025. Description of services were created after billing took place. ➢ Per the 11/17/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 5.25 units of Home Health Aide Services (S9122) on 11/6/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/17/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid.		

	• Agency billed 5 units of Home Health Aide Services (S9122) on 11/7/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/17/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 6 units of Home Health Aide Services (S9122) on 11/10/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/24/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 7 units of Home Health Aide Services (S9122) on 11/11/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/24/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 7 units of Home Health Aide Services (S9122) on 11/12/2025.		

	Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/24/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 5 units of Home Health Aide Services (S9122) on 11/13/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/24/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 5 units of Home Health Aide Services (S9122) on 11/14/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/24/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 6 units of Home Health Aide Services (S9122) on 11/17/2025. Documentation accounted for 0 hours.		

	Documentation on the following date were created after billing took place. ➢ Per the 11/28/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 4.75 units of Home Health Aide Services (S9122) on 11/19/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/28/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 5 units of Home Health Aide Services (S9122) on 11/20/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 11/28/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 5 units of Home Health Aide Services (S9122) on 11/21/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place.		

	➢ Per the 11/28/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 6 units of Home Health Aide Services (S9122) on 11/24/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 12/8/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 7 units of Home Health Aide Services (S9122) on 11/25/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 12/8/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 4.25 units of Home Health Aide Services (S9122) on 11/26/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place.		

	➢ Per the 12/8/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 7.75 units of Home Health Aide Services (S9122) on 11/27/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 12/8/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. • Agency billed 5 units of Home Health Aide Services (S9122) on 11/28/2025. Documentation accounted for 0 hours. Documentation on the following date were created after billing took place. ➢ Per the 12/8/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/13/2026, which was after the claim was submitted and paid. **Individual #2:** September 2026 • Agency billed 8 units of Home Health Aide Services (S9122) on 9/1/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place.		

	➢ Per the 9/15/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 7.25 units of Home Health Aide Services (S9122) on 9/2/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 9/15/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/3/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place ➢ Per the 9/15/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/4/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place.		

	➢ Per the 9/15/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/5/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 9/15/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/8/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 9/29/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 7.5 units of Home Health Aide Services (S9122) on 9/9/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 9/29/2025 Remittance Advice (RA), the agency was paid for the		

	above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/10/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 9/29/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/12/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 9/29/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/15/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily		

	progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/16/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/17/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/18/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it		

	was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 7.75 units of Home Health Aide Services (S9122) on 9/19/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/22/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/23/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it		

	was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/24/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/25/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/6/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 6.75 units of Home Health Aide Services (S9122) on 9/29/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/13/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it		

	was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 9/30/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/13/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/1/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/13/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/2/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/13/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it		

	was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/3/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/13/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/6/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/20/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/7/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/20/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it		

	was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/8/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/20/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/9/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/20/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/10/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/20/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it		

	was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/13/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/27/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 7.25 units of Home Health Aide Services (S9122) on 10/14/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/27/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/15/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/27/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it		

	was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/16/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/27/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 7.25 units of Home Health Aide Services (S9122) on 10/17/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/27/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 10/20/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/31/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it		

	was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 5.75 units of Home Health Aide Services (S9122) on 10/21/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/31/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. ~~• Agency billed units of Home Health Aide Services (S9122) on 10/22/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place.~~ ~~➢ Per the 10/31/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid.~~ • Agency billed 8 units of Home Health Aide Services (S9122) on 10/23/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 10/31/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it		

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	was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 11/3/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 11/17/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 11/4/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 11/17/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 7.75 units of Home Health Aide Services (S9122) on 11/5/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 11/17/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it		

	was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 11/6/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 11/17/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 7.5 units of Home Health Aide Services (S9122) on 11/7/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 11/17/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 11/10/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 11/24/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it		

	was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 11/11/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 11/24/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 11/12/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 11/24/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 11/13/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 11/24/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it		

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	was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 11/27/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 12/8/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid. • Agency billed 8 units of Home Health Aide Services (S9122) on 11/28/2025. Documentation accounted for 0 units. Documentation on the following date were created after billing took place. ➢ Per the 12/8/2025 Remittance Advice (RA), the agency was paid for the above services. Documentation (daily progress notes) received indicated it was created on 1/15/2026, which was after the claim was submitted and paid.		

TAG # MF30 Respite – Home Health Aide – Reimbursement *(Correction)*			
New Mexico Health Care Authority **Developmental Disabilities Supports Division Medically Fragile Waiver (MFW)** **Effective July 1, 2022** **GENERAL PROVIDER REQUIREMENTS** **VI. DOCUMENTATION** A. Provider agencies must maintain all records necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to individuals who are currently receiving services. The provider agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, level of services, and length of service billed. B. The documentation of the billable time spent with an individual are kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record must contain at least the following information: a. date and start and end time of each service encounter or other billable service interval; b. description of what occurred during the encounter or service interval; and c. signature and title of staff providing the service verifying that the service and time are correct. **RESPITE STANDARDS** **III. REIMBURSEMENT** Each provider agency of a service is responsible for developing clinical documentation that identifies the direct support professionals' role in all components of the provision of home care, including assessment information, care planning, intervention, communications, and care coordination and	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Respite Home Health Aide services for 2 of 4 Individuals. **Individual #10:** October 2025 • The Agency billed 1.75 units of Home Health Aide Services (S9122 U1) on 10/20/2025. No documentation was found for on 10/20/2025 to justify the 1.75 units billed. • The Agency billed 3.5 units of Home Health Aide Services (S9122 U1) on 10/24/2025. No documentation was found for on 10/24/2025 to justify the 1.75 units billed. November 2025 • The Agency billed 9 units of Home Health Aide Services (S9122 U1) on 11/7/2025. No documentation was found for on 11/7/2025 to justify the 9 units billed. • The Agency billed 3 units of Home Health Aide Services (S9122 U1) on 11/14/2025. No documentation was found for on 11/14/2025 to justify the 3 units billed. • The Agency billed 7.5 units of Home Health Aide Services (S9122 U1) on 11/15/2025. Documentation received accounted for 4 units.	**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?)*: →	

evaluation. There must be justification in each person's clinical record supporting medical necessity for the care and for the approved Level of Care, that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant's representative, other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget. A. Payment for respite services through the MFW is considered payment in full. B. The respite services must abide by all Federal, State and Human Services Department (HSD) and DOH policies and procedures regarding billable and non-billable items. C. All billed services must not exceed the capped dollar amount for respite services. D. Reimbursement for respite services will be based on the current rate allowed for the services. E. The agency must follow all current billing requirements by the HSD and DOH for respite services. F. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC. G. Service providers have the responsibility to review and assure that the information on the MAD 046 form is current. If the provider identifies an error, he/she will contact the CM or a supervisor at the case management agency immediately to have the error corrected. H. The MFW Program does not consider the following to be respite service duties and will not authorize payment for:			

1. Performing errands for the participant/participant's representative or family that is not program specific; 2. "Friendly visiting," meaning visiting with the person outside of respite work scheduled; 3. Financial brokerage services, handling of participant finances or preparation of legal documents; 4. Time spent on paperwork or travel that is administrative for the provider; 5. Transportation of the medically fragile participant; 6. Pick up and/or delivery of commodities; and 7. Other non-Medicaid reimbursable activities. **NMAC 8.314.3.17 Reimbursement:** Waiver service providers must submit claims for reimbursement to MAD's fiscal contractor for processing. Claims must be filed per the billing manual. Providers instructions in the Medicaid policy must follow all Medicaid billing instructions. See Section 8.302.2 NMAC. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to providers of Medicaid waiver services is made at a predetermined reimbursement rate. [8.314.3.17 NMAC - Rp, 8 .314.3.17 NMAC, 3/1/2018]			

TAG # MF32 Private Duty Nursing Reimbursement			
New Mexico Health Care Authority **Developmental Disabilities Supports Division Medically Fragile Waiver (MFW)** **Effective July 1, 2022** **GENERAL PROVIDER REQUIREMENTS** **VI. DOCUMENTATION** A. Provider agencies must maintain all records necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to individuals who are currently receiving services. The provider agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, level of services, and length of service billed. B. The documentation of the billable time spent with an individual are kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record must contain at least the following information: a. date and start and end time of each service encounter or other billable service interval; b. description of what occurred during the encounter or service interval; and c. signature and title of staff providing the service verifying that the service and time are correct. **Private Duty Nursing** **IV. REIMBURSEMENT:** Each provider of a service is responsible for providing clinical documentation that identifies the DSP's role in all components of the provision of home care: including assessment information, care planning, intervention, communications, and care coordination and evaluation. There must be justification in each	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Private Duty Nursing services for 1 of 1 Individuals. **Individual #4:** September 2025 • The Agency billed 24 units of Private Duty Nursing - LPN Services (T1003) on 10/6/2025. No documentation was found for 9/2/2025 to justify the 24 units billed.		

~~person's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. Services must be reflected in the ISP that is coordinated with the person/person's representative, other caregivers as applicable, and authorized by the approved budget. All services provided, claimed, and billed must have documented justification supporting medical necessity and be covered by the MFW.~~ ~~A. Payment for PDN services through this Medicaid waiver is considered payment in full.~~ ~~B. PDN services must abide by all Federal, State, and HSD and DOH policies and procedures regarding billable and non-billable items.~~ ~~C. Billed services must not exceed the capped dollar amount for LOC.~~ ~~D. PDN services are a Medicaid benefit for children birth to 21years, through the children's EPSDT program.~~ ~~E. The Medicaid benefit is the payer of last resort. Payment for PDN services should not be requested until all other third-party and community resources have been explored and/or exhausted.~~ ~~F. PDN services are a MFW benefit for the 21 year and older enrolled participant. The MFW benefit is the payer of last resort. Payment for waiver services should not be requested or authorized until all other third-party and community resources have been explored and/or exhausted.~~ ~~G. Reimbursement for PDN services will be based on the current rate allowed for the services.~~ ~~H. The HH Agency must follow all current billing requirements by the HSD and the DOH for PDN services.~~			

~~I. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.~~ ~~J. Service providers have the responsibility to review and assure that the information on the MAD 046 form for their services is current. If providers identify an error, they will contact the CM or a supervisor at the case management agency immediately to have the error corrected.~~ ~~K. The MFW Program does not consider the following to be professional PDN duties and will not authorize payment for:~~ ~~1. Performing errands for the participant/participant's representative or family that is not program specific.~~ ~~2. "Friendly visiting," meaning visiting with the medically fragile participant outside of PDN work scheduled.~~ ~~3. Financial brokerage services, handling of participant finances or preparation of legal documents.~~ ~~4. Time spent on paperwork or travel that is administrative for the provider.~~ ~~5. Transportation of the medically fragile participant.~~ ~~6. Pick up and/or delivery of commodities.~~ ~~7. Other non-Medicaid reimbursable activities.~~ ~~**NMAC 8.314.3.17 Reimbursement:** Waiver service providers must submit claims for reimbursement to MAD's fiscal contractor for processing. Claims must be filed per the billing manual. Providers instructions in the Medicaid policy must follow all Medicaid billing instructions. See Section 8.302.2 NMAC. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to providers of Medicaid waiver services is made at a predetermined reimbursement rate. [8.314.3.17 NMAC - Rp, 8.314.3.17 NMAC, 3/1/2018]~~			

Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
Alex Castillo Smith, Deputy Secretary
Kathy Slater Huff, Deputy Secretary
Niki Kozlowski, Acting Deputy Secretary
Alanna Dancis, Acting Medicaid Director

Date:	May 28, 2026
To:	Joyce M. Munoz, BSN, RN, Chief Executive Officer
Provider:	J & J Home Care, Inc.
Address:	1301 W. Grand Avenue
State/Zip:	Artesia, New Mexico 88210
E-mail Address:	joycem@jjhc.org
Region:	Southeast
Survey Dates:	January 5 - 16, 2026
Program Surveyed:	Medically Fragile Waiver (MFW)
Services Surveyed:	Home Health Aide (HHA), Private Duty Nursing (PDN), Respite HHA, and Respite PDN
Survey Type:	Routine

Dear Ms. Munoz,

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
DHI - Quality Management Bureau

Health Care Authority - Division of Health Improvement
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