HEALTH CARE
AUTHORITY

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Dana Flannery, Medicaid Director

(Upheld by IRF 10.2025)

Date:	September 22, 2025
To:	Crystal Lopez-Beck, Area Director
Provider: Address: State/Zip:	Dungarvin New Mexico, LLC 2309 Renard Place SE Albuquerque, New Mexico 87106
E-mail Address:	clopezbeck@dungarvin.com
CC: E-Mail Address:	Scott Good, State Director scgood@dungarvin.com
Region: Survey Date:	Metro August 11 – 22, 2025
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Supported Living, Family Living, Customized In-Home Supports, and Customized Community Supports
Survey Type:	Routine
Team Leader:	Elizabeth Vigil, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Karlene Anderson, MSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; William J. Easom, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Gabriella Marquez, MA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jennifer Marquez Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Lopez-Beck and Mr. Good;

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

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

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

The following tags are identified as Condition of Participation Level:

- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- Tag # 1A22 Agency Personnel Competency ***(Upheld by IRF)***
- Tag # 1A09 Medication Delivery Routine Medication Administration
- Tag # 1A31 Client Rights / Human Rights

The following tags are identified as Standard Level:

- Tag # 1A08.1 Administrative and Residential Case File: Progress Notes ***(Upheld by IRF)***
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*
- Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)
- Tag # 1A20 Direct Support Professional Training
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)
- Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)
- Tag # IS30 Customized Community Supports Reimbursement

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

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

Corrective Action for Current Citation:

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

On-going Quality Assurance/Quality Improvement Processes:

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

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

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

1. **Quality Management Bureau, Kayla Benally, Healthcare Surveyor Advanced / Plan of Correction Coordinator** at kayla.benally@hca.nm.gov

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

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

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

Billing Deficiencies:
If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a "Void/Adjust" claim or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HCA/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
PO Box 2348
1474 Rodeo Road
Santa Fe, New Mexico 87505

If you have questions and would like to speak with someone at HCA/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
Attention: IRF request/QMB

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

Please contact the Plan of Correction Coordinator, Kayla Benally at 505-670-6290 or email at: kayla.benally@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,

Elizabeth Vigil

Elizabeth Vigil
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	August 11, 2025
Contact:	**Dungarvin New Mexico, LLC** Scott Good, State Director **HCA/DHI/QMB** Elizabeth Vigil, Team Lead/Healthcare Surveyor
Entrance Conference Date:	*(Note: Entrance meeting waived by provider)*
Exit Conference Date:	August 22, 2025
Present:	**Dungarvin New Mexico, LLC** Scott Good, State Director Bill Myers, Regional Director Crystal Lopez-Beck, Area Director Geoff Chavez, Quality Program Coordinator Angie Prokash, Health Service Coordinator Eric Clupper, Nurse Jennifer Jones, Nurse Judy Bencomo, Program Director Yacoub Hussein, Program Director Mary Tharpe, Program Director **HCA/DHI/QMB** Elizabeth Vigil, Team Lead/Healthcare Surveyor Valerie V. Valdez, MS, Quality Management Bureau Chief Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Karlene Anderson, MSW, Healthcare Surveyor William J. Eason, MPA, Healthcare Surveyor Gabbriella Marquez, MA, Healthcare Surveyor Jennifer Marquez, Healthcare Surveyor **DDSD - Metro Regional Office** Fleur Dahl, Provider Support Coordinator
Total Wellness Visits Completed (Individuals Seen):	27
Total Compliance Survey Sample Size:	17 10 - Supported Living 2 - Family Living 4 - Customized In-Home Supports 12 - Customized Community Supports
Total Compliance Survey Homes Visits	13
❖ Supported Living Homes Visited	7 *Note: The following Individuals share a SL residence:* • #4, 6 • #8, 9 • #10, 14

❖ Family Living Homes Visited	2
❖ Customized In-Home Support Home Visited	4
Persons Served Records Reviewed	17
Persons Served Interviewed	13
Persons Served Observed	4 *(Note: Four Individuals chose not to participate in the interview process)*
Direct Support Professional Records Reviewed	97 *(Note: One DSP performs dual roles as a Service Coordinator)*
Direct Support Professional Interviewed	14
Service Coordinator Records Reviewed	4 *(Note: One Service Coordinator performs dual roles as a DSP)*
Administrative Interview	1
Nurse Interview	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Oversight of Individual Funds
- Individual Agency / Residential / Site Case Files, including, but not limited to:
    - Individual Service Plans
    - Progress on Identified Outcomes
    - Healthcare Plans
    - Medication Administration Records
    - Physician Orders
    - Therapy Plans
    - Healthcare Documentation Regarding Appointments and Required Follow-Up
    - Other Required Health Information / Therap Required Documents
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files:
    - Training Records
    - Caregiver Criminal History Screening Records
    - Employee Abuse Registry
- Interviews with the Individuals and Agency Personnel
- Human Rights Committee Notes and Meeting Minutes
- Quality Assurance / Improvement Plan
- Agency Policy and Procedure 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, Kayla Benally at 505-670-6290 or email at: kayla.benally@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 kayla.benally@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 Conduent for the deficiencies cited in the Report of Findings.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

Attachment B

Division of Health Improvement / Quality Management Bureau
QMB Determination of Compliance Process

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

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

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

Conditions of Participation (CoPs)

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

Service Domains and CoPs for Living Care Arrangements and Community Inclusion are as follows:

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

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

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

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

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

- **1A20 -** Direct Support Personnel Training

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

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

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

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

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

Attachment C

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

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

Instructions:
1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Bureau Chief **within 10 business days** of receipt of the final Report of Findings **(*Note: No extensions are granted for the IRF)*.**
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: Microsoft Word - IRF-QMB-Form.doc 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.
5. 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.

Attachment D

QMB Determinations of Compliance

Compliance:

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

Partial-Compliance with Standard Level Tags:

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

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

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

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

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

Non-Compliance:

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

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

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

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

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A08.1 Administrative and Residential Case File: Progress Notes ***(Upheld by IRF)***	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: … 5. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 6. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 1 of 17 Individuals. Review of the Agency administrative individual case files revealed the following items were not found and/or did not meet the requirement: **Residential Case File:** **Supported Living Progress Notes/Daily Contact Logs:** • Individual #3 - None found for 8/1 – 3, 2025. *(Date of home visit: 8/12/2025)* *(Findings for Individual #3 Upheld by IRF)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

service delivery, as well as data tracking only for the services provided by their agency. 7. The current Client File Matrix found in Appendix A: Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.			

Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	Standard Level Deficiency		
NMAC 8.371.5.16 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - IMPLEMENTATION OF THE ISP: The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan. **8.371.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP)** **C.** Outcomes: **(1)** The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP. **(2)** Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver. **E.** Action plans:	Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 17 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Customized In-Home Supports Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #2 • According to the Live Outcome; Action Step for "… will work on a portion of the large home project" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/2025 - 7/2025.	**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?)*: →	

(1) Specific ISP action plans that will assist the individual in achieving each identified, desired outcome shall be developed by the IDT and stated in the ISP. The IDT establishes the action plan of the ISP, as well as the criteria for measuring progress on each action step. **(2)** Service providers shall develop specific action plans and strategies (methods and procedures) for implementing each ISP desired outcome. Timelines for meeting each action step are established by the IDT. Responsible parties to oversee appropriate implementation of each action step are determined by the IDT. **(3)** The action plans, strategies, timelines and criteria for measuring progress, shall be relevant to each desired outcome established by the IDT. The individual's definition of success shall be the primary criterion used in developing objective, quantifiable indicators for measuring progress. Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 6: 6.10 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records) … All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain			

individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: … 6. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 7. The current Client File Matrix found in Appendix A: Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.			

Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Records must contain information of concerns related to abuse, neglect or exploitation. 3. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data,	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 10 of 12 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, not current and/or did not meet the requirement: **ISP Teaching and Support Strategies:** ***Individual #15:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "… will choose a holiday that she wants to decorate for." • "… will decorate the area." **Healthcare Passport:** • Not Found (#3, 12) **Comprehensive Aspiration Risk Management Plan:** • Not Found (#7, 8, 9, 10, 15) **Health Care Plans:** • A1c Levels (#14) • Body Mass Index (#6) • Constipation (#6) • Endocrine (#6, 14) • History of Neuroleptic Malignant Syndrome (#6) • PRN Psychoactive Medications (#6) • Respiratory (#14)	**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?)*: →	

annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 6. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 7. The current Client File Matrix found in Appendix A: Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. **20.3 Record Access for Direct Support Professionals (DSP) during Service Delivery:** DSP must have access to records, plans, and forms needed to adequately provide and document the type of service and specific scope of service being provided at the time. **20.5 Communication and Documentation in Therap:** Therap is a secure online documentation system required to be used by specific New Mexico DD Waiver Provider Agencies. Use of the required elements of Therap are intended to improve agency monitoring, health care coordination for individuals, and overall quality of services. **20.5.3 *Health Passport and Consultation Form*** **20.5.4 *Health Tracking*** **20.5.5 *Nursing Assessment Tracking*** **Chapter 13 Nursing Services: 13.2.9.1 Health Care Plans (HCP):** Health Care Plans are created to provide guidance for the Direct	• Seizures (#6, 14) • Skin and Wound (#6, 13, 14) • Skin Integrity (#6, 14)		

Support Professionals (DSP) to support health related issues. Approaches that are specific to nurses may also be incorporated into the HCP. Healthcare Plans are based upon the eCHAT and the nursing assessment of the individual's needs. 1. The Primary Provider Agency nurse (PPN) is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary report which is indicated by "R" in the HCP column. At the nurse's sole discretion, based on prudent nursing practice, HCPs may be combined where clinically appropriate. The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by "C" on the e-CHAT summary report. The nurse may also create other HCPs that the nurse determines are warranted.			

Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Records must contain information of concerns related to abuse, neglect or exploitation. 3. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports,	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 2 of 12 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Positive Behavioral Supports Plan:** • Not Found (#7, 9) **Behavior Crisis Intervention Plan:** • Not Found (#9)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 6. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 7. The current Client File Matrix found in Appendix A: Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A20 Direct Support Professional Training	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 17 Training Requirements: 17.1 Training Requirements for Direct Support Professional and Direct Support Supervisors:** Direct Support Professional (DSP) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports… The training shall address at least the following: • Individual Specific Training • First Aid • CPR • Assisting With Medication Delivery (AWMD) Part 1 Session 1 & 2 **…** **17.1.13 Training Requirements for Service Coordinators (SC):** Service Coordinators (SCs) refer to staff at agencies providing the following services: Supported Living, Family Living, Customized In-home Supports, Intensive Medical Living, Customized Community Supports, Community Integrated Employment, and Crisis Supports…The training shall address at least the following: • Individual Specific Training • First Aid • CPR • Assisting With Medication Delivery (AWMD) Part 1 Session 1 & 2 … ***(see DDW Standards Chapter 17 Training Requirements for all training specifics)***	After an analysis of the evidence it has been determined the following finding resulted in a negative outcome. Based on record review, the Agency did not ensure Orientation and Training requirements were met for 2 of 100 Direct Support Professional, Direct Support Supervisory Personnel and / or Service Coordinators. Review of Agency training records found no evidence of the following required HCA/DDSD trainings being completed: **First Aid:** • Not Found (#512) • Expired (#500) **CPR:** • Not Found (#512) • Expired (#500)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 1A22 Agency Personnel Competency *(Upheld by IRF)*	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 17 Training Requirements:** **17.9 Individual-Specific Training Requirements:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence. Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. The trainer must observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not ensure training competencies were met for 7 of 14 Direct Support Professional. **When DSP were asked, if the Individual had Positive Behavioral Supports Plan (PBSP), If have they had been trained on the PBSP and what does the plan cover, the following was reported:** • DSP #602 stated, "It was discontinued a couple months ago." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan and DSP are required to be trained. *(Note: Per Budget 6/23/2025 – 6/22/2026 Individual currently receives BSC).* (Individual #11) **When DSP were asked, if the Individual had a Comprehensive Aspiration Risk Management Plan (CARMP) and if they had been trained on the CARMP, the following was reported:** • DSP #576 stated, "No." As indicated by the Aspiration Risk Screening Tool the individual requires a Comprehensive Aspiration Risk Management Plan (CARMP). (Individual #9) **When DSP were asked, if the Individual's had Health Care Plans, where could they be located and if they had been trained, the following was reported:**	**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?)*: →	

additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported…	• DSP #526 stated, "Acne." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Boddy Mass Index and Endocrine. (Individual #4) • DSP #526 stated, "Blood sugars, aspiration risk, seizure disorder, diabetic." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual additionally requires Health Care Plans for Body Mass Index, Constipation Management, Malignant Syndrome, Skin and Wound and Use of PRN Medications. (Individual #6) • DSP #510 stated, "I know he has one for aspiration." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual additionally requires Health Care Plans for Bowel Bladder Function, Communication/Vision/Hearing, Falls, Seizure Disorder, Skin Integrity, Skin and Wound, Supports for Hydration or Risk for Dehydration. (Individual #7) • DSP #576 stated, "Falls and aspiration." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual additionally requires Health Care Plans for Complains of or Demonstrates Signs/Symptoms Reflux, Constipation Management, Respiratory, additionally the Individual Specific Training section of the ISP indicates the Individual requires Health Care Plans for Body Mass Index. (Individual #8) • DSP #576 showed the surveyor the computer screen which displayed the Healthcare Plan Aspiration and then stated, "This is all she has." As indicated by the Electronic Comprehensive Health		

	Assessment Tool, the Individual additionally requires Health Care Plans for Complains of or Demonstrates Sign/Symptoms of Reflux, Falls, Neuro (Devices and implants: Cerebral Shunt, Baclofen Pump, VNS), Seizure Disorder, Skin Integrity, Skin and Wound, Status of Care/Hygiene, Supports for Hydration or Risk of Dehydration. (Individual #9) • DSP #572 stated, "Not that I am aware of." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Seizure Disorder, Skin Integrity and Skin and Wound. (Individual #18) **When DSP were asked, if the Individual had any food and / or medication allergies that could be potentially life threatening, the following was reported:** • DSP #561 stated, "No, no allergies." As indicated by Healthcare Passport the individual is allergic to Prednisone. (Individual #3) **When DSP were asked, if the staff needs to monitor for <u>DEHYDRATION</u>, the following was reported:** • DSP #510 stated, "No, not in a formal way." As indicated by the Electronic Comprehensive Health Assessment Tool the Individual has a Health Care Plan for Supports for Hydration or Risk of Dehydration. (Individual #7) **When DSP were asked, what are the steps you need to take before assisting an individual with PRN medication, the following was reported:**		

	• DSP #594 stated, “I get permission from his parents.” Per DDSD standards DSP not related to the Individual must contact nurse prior to assisting with medication. (Individual #2) *(Finding for DSP #594 Upheld by IRF)*		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag #1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 3 Safeguards: 3.1 Decisions about Health Care or Other Treatment: Decision Consultation Process:** There are a variety of approaches and available resources to support decision making when desired by the person. The decision consultation process assists participants and their health care decision makers to document their decisions. It is important for provider agencies to communicate with guardians to share with the Interdisciplinary Team (IDT) Members any medical, behavioral, or psychiatric information as part of an individual's routine medical or psychiatric care. **3.1.1 Decision about Health Care or Other Treatment Decision Consultation:** Decisions are the sole domain of waiver participants; their guardians or healthcare decision makers and decisions can be made that are compatible with their personal and cultural values. Provider Agencies and Interdisciplinary Teams (IDTs) are required to support the informed decisions made by supporting access to medical consultation, information, and other available resources according to the following: The Decision Consultation Process (DCP) is documented on the Decision Consultation Form (DCF) and is used for recommendations when a person or his/her guardian/healthcare decision maker has concerns, needs more information, or has decided not to follow all or part of a	Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 1 of 17 individuals receiving Living Care Arrangements and Community Inclusion. Review of the Agency administrative individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Annual Physical Exam:** • Individual #4 - As indicated by collateral documentation reviewed, exam was completed on 5/7/2025. Follow-up was to be completed in 8 weeks. No evidence of follow-up found.	**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?)*: →	

recommendation from a professional or clinician… **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Records must contain information of concerns related to abuse, neglect or exploitation. 3. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.			

6. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 7. The current Client File Matrix found in Appendix A: Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 8. All records must be retained for six (6) years and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5 Communication and Documentation in Therap:** Therap is a secure online documentation system required to be used by specific New Mexico DD Waiver Provider Agencies. Use of the required elements of Therap are intended to improve agency monitoring, health care coordination for individuals, and overall quality of services. **20.5.3 *Health Passport and Consultation Form:*** The Health Passport and Consultation form are generated within Therap. The standardized combination of documents includes all information that are required for medical consultation during an appointment and other health coordination activities: 1. The Primary Provider must keep the Health Passport and Consultation form updated in concert with critical information and changes from the IDT, including secondary provider agencies, medical providers for the individual. The Health Passport pulls from Individual Demographics, Health Tracking and eCHAT. a. The primary provider must notify secondary providers when a new eCHAT is completed or contact information is updated.			

2. The Primary and Secondary Provider Agencies must ensure that a current copy of the *Health Passport* and *Consultation* forms are printed and available at all service delivery sites. a. Updated forms must be sent to each site after eCHAT and/or Contact Updates. b. Outdated version of both unused forms must be removed from all sites. 3. Primary and Secondary Provider Agencies must assure that the current *Health Passport* and *Consultation* form accompany each person when taken by the provider to a medical appointment, urgent care/emergency room visits, emergency service encounter, or are admitted to a hospital or nursing home for details see Health Tracking: Appointments **20.5.4 *Health Tracking*** **20.5.5 *Nursing Assessment Tracking*** **Chapter 13 Nursing Services: 13.2.3 General Requirements Related to Orders, Implementation, and Oversight:** 1. Each person has a licensed primary care practitioner and receives an annual physical examination, dental care and specialized medical/behavioral care as needed. PPN communicate with providers regarding the person as needed. 2. Orders from licensed healthcare providers are implemented promptly and carried out until discontinued. a. The nurse will contact the ordering or on call practitioner as soon as possible if the order cannot be implemented due to the person's or guardian's refusal or due to other issues delaying implementation of the order. The nurse must clearly document the issues and all attempts to resolve the problems with all involved parties.			

b. Not implementing orders by a licensed healthcare provider is considered neglect, unless a Decision Consultation Form is filled out by participant or guardian, or a healthcare decision maker making this decision. c. Based on prudent nursing practice, if a nurse determines to hold a practitioner's order, they are required to immediately document the circumstances and rationale for this decision and to notify the ordering or on call practitioner as soon as possible, but no later than the next business day. d. If the person resides with their biological family, and there are no nursing services budgeted, the family is responsible for implementation or follow up on all orders from all providers.			

Tag # 1A09 Medication Delivery Routine Medication Administration	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 10 Living Care Arrangements (LCA): 10.3.5 Medication Assessment and Delivery:** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training; 2. the nursing and DSP functions identified in the Chapter 13.3 Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20 5.7 Medication Administration Record (MAR) **Chapter 20 Provider Documentation and Client Records: 20.5.7 Medication Administration Record (MAR):** Administration of medications apply to all provider agencies of the following services: living supports, customized community supports, community integrated employment, intensive medical living supports. 1. Primary and secondary provider agencies are to utilize the Medication Administration Record (MAR) online in Therap. 2. Medication/Treatment must be recorded online per assisting with medication delivery per the DDSD Assisting with Medication Delivery (AWMD) program. 3. Family Living Providers may opt not to use MARs if they are the **sole** provider who supports the person and are related by affinity or consanguinity. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, a	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of July and August, 2025. Based on record review, 3 of 10 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #6 August 2025 As indicated by the Medication Administration Records the following medication is to be taken, however was not found in the home: • Dapsone 5% gel (2 times daily) Individual #9 July 2025 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Acidophilus (1 time daily) – Blank 7/31 (6:00 PM) • Blink Tears 0.25% Eye Drop (3 times daily) – Blank 7/31 (8:00 PM) • Cyclosporine 0.05% (2 times daily) – Blank 7/31 (7:00 PM) • Divalproex SOD Dr 500 MG (1 time daily) – Blank 7/31 (8:00 PM)	**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?)*: →	

MAR online in Therap must be created and used by the DSP. 4. Provider Agencies must configure and use the MAR when assisting with medication. 5. Provider Agencies Continually communicate any changes about medications and treatments between Provider Agencies to assure health and safety. 6. Provider agencies must include the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed. b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine and PRN medications and other treatments; all over the counter (OTC) or "comfort" medications or treatments; all self-selected herbal preparation approved by the prescriber, and/or vitamin therapy approved by prescriber. c. Documentation of all time limited or discontinued medications or treatments. d. The initials of the person administering or assisting with medication delivery. e. Documentation of refused, missed, or held medications or treatments. f. Documentation of any allergic reaction that occurred due to medication or treatments. g. For PRN medications or treatments including all physician approved over the counter medications and herbal or other supplements: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period;	• Lacosamide 100 MG (2 times daily) – Blank 7/31 (8:00 PM) • Melatonin 5 MG (1 time daily) – Blank 7/31 (8:00 PM) • Mirtazapine 15 MG (1 time daily) – Blank 7/31 (8:00 PM) • Olanzapine 5 MG (1 time daily) – Blank 7/31 (8:00 PM) • Oxcarbazepine 600 MG (2 times daily) – Blank 7/31 (8:00 PM) Individual #16 July 2025 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Atorvastatin 10 mg (1 time daily) – Blank 7/8, 23 (8:00 PM) • Benztropine 1 mg (2 times daily) – Blank 7/8, 23 (8:00 PM) • Celecoxib 200 mg (2 times daily) – Blank 7/8, 23 (8:00 PM) • Diazepam 2 mg (2 times daily) – Blank 7/8, 23 (8:00 PM) • Docusate Sodium 100 mg (2 times daily) – Blank 7/8, 23 (8:00 PM) • Ferrous Sulfate 325 mg (2 time daily) – Blank 7/8, 23 (8:00 PM) • Fluvoxamine Maleate 100 mg (2 time daily) – Blank 7/8, 23 (8:00 PM)		

ii. clear follow-up detailed documentation that the DSP contacted the agency nurse or physician service prior to assisting with the medication or treatment; and iii. documentation of the effectiveness of the PRN medication or treatment. **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24-hour period.	• Gabapentin 100 mg (1 time daily) – Blank 7/8, 23 (8:00 PM) • Minocycline 100 mg (2 times daily) – Blank 7/8, 23 (8:00 PM) • Olanzapine 10 mg (1 time daily) – Blank 7/8, 23 (8:00 PM) • Propranolol 20 mg (2 times daily) – Blank 7/8, 23 (8:00 PM) • Sodium Fluoride 5000 PPM (2 times daily) – Blank 7/8, 23 (8:00 PM) • Topiramate 100 mg (1 time daily) – Blank 7/8, 23 (8:00 PM) • Triad Hydrophilic Cream (2 times daily) – Blank 7/5 (8:00 AM and 2:00 PM)		

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 3 Safeguards: 3.1 Decisions about Health Care or Other Treatment: Decision Consultation Process:** There are a variety of approaches and available resources to support decision making when desired by the person. The decision consultation process assists participants and their health care decision makers to document their decisions. It is important for provider agencies to communicate with guardians to share with the Interdisciplinary Team (IDT) Members any medical, behavioral, or psychiatric information as part of an individual's routine medical or psychiatric care. **3.1.1 Decision about Health Care or Other Treatment Decision Consultation:** Decisions are the sole domain of waiver participants; their guardians or healthcare decision makers and decisions can be made that are compatible with their personal and cultural values. Provider Agencies and Interdisciplinary Teams (IDTs) are required to support the informed decisions made by supporting access to medical consultation, information, and other available resources according to the following: The Decision Consultation Process (DCP) is documented on the Decision Consultation Form (DCF) and is used for recommendations when a person or his/her guardian/healthcare decision maker has concerns, needs more information, or has decided not to follow all or part of a recommendation from a professional or clinician…	Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 1 of 17 individuals. Review of the Agency administrative individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Electronic Comprehensive Health Assessment Tool (eCHAT):** • Not Current (#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?)*: →	

Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Records must contain information of concerns related to abuse, neglect or exploitation. 3. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 6. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of			

service delivery, as well as data tracking only for the services provided by their agency. 7. The current Client File Matrix found in Appendix A: Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. **20.5 Communication and Documentation in Therap:** Therap is a secure online documentation system required to be used by specific New Mexico DD Waiver Provider Agencies. Use of the required elements of Therap are intended to improve agency monitoring, health care coordination for individuals, and overall quality of services. **20.5.3** ***Health Passport and Consultation Form*** **20.5.4** ***Health Tracking*** **20.5.5** ***Nursing Assessment Tracking*** **Chapter 13 Nursing Services: 13.1 Overview of The Nurse's Role in The DD Waiver and Larger Health Care System:** Routine medical and healthcare services are accessed through the person's Medicaid State Plan benefits and through Medicare and/or private insurance for persons who have these additional types of insurance coverage. DD Waiver health related services are specifically designed to support the person in the community setting and complement but may not duplicate those medical or health related services provided by the Medicaid State Plan or other insurance systems. **13.2.7 Documentation Requirements for all DD Waiver Nurses**			

13.2.8 Electronic Nursing Assessment and Planning Process **13.2.8.1 Medication Administration Assessment Tool (MAAT)** **13.2.8.2 Aspiration Risk Management Screening Tool (ARST)** **13.2.8.3 The Electronic Comprehensive Health Assessment Tool (e-CHAT)** **13.2.9.1 Health Care Plans (HCP)**			

Tag # 1A31 Client Rights / Human Rights	Condition of Participation Level Deficiency		
NMAC 8.371.3 RIGHTS OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY **8.371.3.10 CLIENT RIGHTS:** Unless expressly modified by court order or specifically granted to a guardian or conservator, all clients have: A. the same legal rights guaranteed to all other individuals under the United States Constitution, New Mexico State Constitution, and federal and state laws;… **8.371.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:** A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens their physical safety; or (3) as provided for in Subsection N of 8.371.3.10 NMAC. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not ensure the rights of Individuals were not restricted or limited for 1 of 17 Individuals. <u>No documentation</u> was found regarding Human Rights Approval for the following: • Checking on the individual every 5 minutes when he's in his room. - No evidence found of Human Rights Committee approval. (Individual #4) • Calling 911 to request CIT. - No evidence found of Human Rights Committee approval. (Individual #4)	**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?)*: →	

support policies or other authority regulation or policy. Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 2 Human Rights:** Civil rights apply to everyone including all waiver participants. Everyone including family members, guardians, advocates, natural supports, and Provider Agencies have a responsibility to make sure the rights of persons receiving services are not violated. All Provider Agencies play a role in person-centered planning (PCP) and have an obligation to contribute to the planning process, always focusing on how to best support the person and protecting their human and civil rights. ***2.2*** **Home and Community Based Services (HCBS): Consumer Rights and Freedom:** People with I/DD receiving DD Waiver services, have the same basic legal, civil, and human rights and responsibilities as anyone else. Rights shall never be limited or restricted unnecessarily, without due process and the ability to challenge the decision, even if a person has a guardian. Rights should be honored within any assistance, support, and services received by the person.. **Chapter 3 Safeguards: 3.4.5 Interventions Requiring HRC Review and Approval:** HRCs must review any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies that include a restriction of an individual's rights; this HRC should occur prior to implementation of the strategy or strategies proposed. Categories requiring an HRC review include, but are not limited to, the following: 1. response cost (See the BBS Guidelines for Using Response Cost);			

2. restitution (See BBS Guidelines for Using Restitution); 3. emergency physical restraint (EPR); 4. routine use of law enforcement as part of a BCIP; 5. routine use of emergency hospitalization procedures as part of a BCIP; 6. use of point systems; 7. use of intense, highly structured, and specialized treatment strategies, including levels systems with response cost or failure to earn components; 8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons; 9. use of PRN psychotropic medications; 10. use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey gloves for biting hand); 11. use of bed rails; 12. use of a device and/or monitoring system through RPST may impact the person's privacy or other rights; or 13. use of any alarms to alert staff to a person's whereabouts.			

Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 10 Living Care Arrangement (LCA): 10.3.7 Requirements for Each Residence (SL, FL, IMLS):** Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence: 1. has basic utilities, i.e., gas, power, water, telephone, and internet access; 2. promotes a safe environment free of any abuse, neglect, and exploitation; 3. supports telehealth, and/ or family/friend contact on various platforms or using various devices; 4. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher; 5. has a general-purpose first aid kit; 6. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift; 7. has water temperature that does not exceed a safe temperature (110° F). Anyone with a history of being unsafe in or around water while bathing, grooming, etc. or with a history of at least one scalding incident will have a regulated temperature control valve or device installed in the home; 8. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP; 9. has an emergency placement plan for relocation of people in the event of an	Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 2 of 9 Living Care Arrangement residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Supported Living Requirements:** • Water temperature in home exceeds safe temperature (120^0 F): • Water temperature in home measured 121.4^0 F (#10, 14) **Family Living Requirements:** • Water temperature in home exceeds safe temperature (120^0 F): • Water temperature in home measured 130^0 F (#12) *Note: The following Individuals share a residence:* • #4, 6 • #8, 9 • #10, 14	**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?)*: →	

emergency evacuation that makes the residence unsuitable for occupancy; 10. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; 11. supports environmental modifications, remote personal support technology (RPST), and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; 12. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed; 13. has the phone number for poison control within line of site of the telephone; 14. has general household appliances, and kitchen and dining utensils; 15. has proper food storage and cleaning supplies; 16. has adequate food for three meals a day and individual preferences; 17. has at least two bathrooms for residences with more than two residents; 18. training in and assistance with community integration that include access to and participation in preferred activities to include providing or arranging for transportation needs or training to access public transportation; and 19. has Personal Protective Equipment available, when needed. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. 3. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the			

Therap web-based system using computers or mobile devices are acceptable. **20.3 Record Access for Direct Support Professional (DSP) during Service Delivery:** DSP must have access to records, plans, and forms needed to adequately provide and document the type of service and specific scope of service being provided at the time.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**		
NMAC 8.302.2 BILLING FOR MEDICAID SERVICES Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 21: Billing Requirements; 23.1 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and 3. Details of the services provided. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer…	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports services for 1 of 12 individuals. Individual #7 May 2025 • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 5/28/2025. Documentation received accounted for 0 units as services were provided concurrently with another service on 5/28/2025.	**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?)*: →	

21.7 Billable Activities: Specific billable activities are defined in the scope of work and service requirements for each DD Waiver service. In addition, any billable activity must also be consistent with the person's approved ISP. **21.9 Billable Units**: The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit, or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units. **21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following: 1. A day is considered 24 hours from midnight to midnight. 2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period. 3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months. **21.9.2 Requirements for Monthly Units:** For services billed in monthly units, a Provider Agency must adhere to the following: 1. A month is considered a period of 30 calendar days. 2. Face-to-face billable services shall be provided during a month where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. **21.9.4 Requirements for 15-minute and hourly units:** For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following:			

1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2. 2. Services that last in their entirety less than eight minutes cannot be billed.			

HEALTH CARE
AUTHORITY

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

Date:	November 19, 2025
To:	Crystal Lopez-Beck, Area Director
Provider: Address: State/Zip:	Dungarvin New Mexico, LLC 2309 Renard Place SE Albuquerque, New Mexico 87106
E-mail Address:	clopezbeck@dungarvin.com
CC: E-Mail Address:	Scott Good, State Director scgood@dungarvin.com
Region: Survey Date:	Metro August 11 – 22, 2025
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Supported Living, Family Living, Customized In-Home Supports, and Customized Community Supports
Survey Type:	Routine

Dear Ms. Lopez-Beck and Mr. Good:

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,

Kayla R. Benally, BSW

Kayla R. Benally, BSW
Healthcare Surveyor Advanced/Plan of Correction Coordinator
DHI - Quality Management Bureau