HEALTH CARE
AUTHORITY

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Kathy Slater Huff, Deputy Secretary
Kyra Ochoa, Deputy Secretary
Dana Flannery, Medicaid Director

(Modified by IRF 12.2024)

Date:	November 27, 2024
To:	Cheryl Harrison, Area Director
Provider: Address: State/Zip:	Dungarvin New Mexico, LLC 2309 Renard Place SE Suite# 205 Albuquerque, New Mexico 87106
E-mail Address:	caharrison@dungarvin.com
CC:	Scott Good, State Director scgood@dungarvin.com Bill Myers, West Region Director bmyers@dungarvin.com Robert Bachicha, Vice President of Operations rbachicha@dungarvin.com
Region: Survey Date:	Northwest (Farmington) October 7 - 18, 2024
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Supported Living, Family Living, Customized In-Home Supports; Customized Community Supports
Survey Type:	Routine
Team Leader:	Armida Medina, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Ashley Gueths, BACJ, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Elizabeth Vigil, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Kayla Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Karlene Anderson, MSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Harrison,

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:

Non-Compliance: This determination is based on noncompliance with 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 or any amount of Standard Level Tags with 6 or more 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 # 1A32 Administrative Case File: Individual Service Plan Implementation
- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- Tag # 1A22 Agency Personnel Competency
- Tag # 1A25.1 Caregiver Criminal History Screening ***(Modified by IRF)***
- Tag # 1A26.1 Employee Abuse Registry ***(Modified by IRF)***
- Tag # 1A09 Medication Delivery Routine Medication Administration
- Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication

The following tags are identified as Standard Level:

- Tag # 1A08.1 Administrative and Residential Case File: Progress Notes
- Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*
- Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)
- Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements
- Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)
- Tag # 1A20 Direct Support Professional Training
- Tag # 1A26 Employee Abuse Registry ***(Upheld by IRF)***
- Tag # 1A43.1 General Events Reporting: Individual Reporting
- Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider
- Tag # 1A31.2 Human Right Committee Composition
- Tag # 1A33.1 Board of Pharmacy – License
- Tag # LS06 Family Living Requirements
- Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)
- Tag # LS26 Supported Living Reimbursement
- Tag # LS27 Family Living 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, Monica Valdez, Plan of Correction Coordinator** at MonicaE.Valdez@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, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@hca.nm.gov if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Armida Medina

Armida Medina
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	October 7, 2024
Contact:	**Dungarvin New Mexico, LLC** Scott Good, State Director **HCA/DHI/QMB** Armida Medina, Team Lead/Healthcare Surveyor
Entrance Conference Date:	October 7, 2024
Present:	**Dungarvin New Mexico, LLC** Scott Good, State Director Cheryl Harrison, Area Director **HCA/DHI/QMB** Armida Medina, Team Lead/Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Ashley Gueths, BACJ, Healthcare Surveyor Elizabeth Vigil, Healthcare Surveyor Kayla Benally, BSW, Healthcare Surveyor
Exit Conference Date:	October 18, 2024
Present:	**Dungarvin New Mexico, LLC** Scott Good, State Director Cheryl Harrison, Area Director Bill Myers, West Region Director Susan Nichols, Program Director Tabatha Hekpah, Program Director Gwen Henderson, Business Manager Sharon Carpenter, Nurse Michelle Trana, Program Director **HCA/DHI/QMB** Armida Medina, Team Lead/Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Ashley Gueths, BACJ, Healthcare Surveyor Elizabeth Vigil, Healthcare Surveyor Kayla Benally, BSW, Healthcare Surveyor **DDSD - Northwest Regional Office** Aaron Joplin, Regional Director
Administrative Locations Visited:	0 (*Administrative portion of survey completed remotely*)
Total Wellness Visits Completed (Individuals Seen):	20
Total Compliance Survey Sample Size:	13 6 - Supported Living 3 - Family Living 4 - Customized In-Home Supports 8 - Customized Community Supports
Total Compliance Survey Homes Visits	11

❖ Supported Living Homes Visited	5 *Note: The following Individuals share a SL residence:* • #1, 5
❖ Family Living Homes Visited	3
❖ Customized In-Home Support Home Visited	3
Persons Served Records Reviewed	13
Persons Served Interviewed	13
Direct Support Professional Records Reviewed	53 *(Note: Six DSPs perform dual roles as Service Coordinators)*
Direct Support Professional Interviewed	11
Substitute Care/Respite Personnel Records Reviewed	1
Service Coordinator Records Reviewed	6 *(Note: Six Service Coordinators perform dual roles as 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, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@hca.nm.gov for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your respective Regional DDSD Office.
4. Submit your POC to via email to MonicaE.valdez@hca.nm.gov. Please also submit your POC to your Developmental Disabilities Supports Division Regional Office for region of service surveyed.
5. ***Do not submit supporting documentation*** (evidence of compliance) to QMB ***until after*** **your POC has been approved** by the QMB.
6. QMB will notify you when your POC has been "approved" or "denied."
    a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45-business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
    b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45-business day limit is in effect.
    c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
    d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
    e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

Once your POC has been approved by the QMB Plan of Correction Coordinator, you must submit copies of documents as evidence that all deficiencies have been corrected. You must also submit evidence of the ongoing Quality Assurance/Quality Improvement processes.

1. Your internal documents are due within a *maximum* of 45-business days of receipt of your Report of Findings.
2. Please submit your documents electronically according to the following: If documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to the State email account. If documents contain PHI **do not** submit PHI directly to the State email account. *You may submit PHI **only** when **replying** to a **secure** email received from the State email account*. When possible, please submit requested documentation using a "zipped/compressed" file to reduce file size. You may also submit documents via S-Comm (Therap), or another electronic format, i.e., flash drive.
3. All submitted documents *must be annotated*; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to 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

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

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

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

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

Conditions of Participation (CoPs)

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

Service Domains and CoPs for 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 Professional Training
- **1A22 -** Agency Personnel Competency

- **1A37 –** Individual Specific Training

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

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

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

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 Coordination - Nurse Availability / Knowledge
- **1A31 –** Client Rights/Human Rights
- **LS25.1 –** Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

Attachment C

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

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

Instructions:
1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Bureau Chief **within 10 business days** of receipt of the final Report of Findings **(*Note: No extensions are granted for the IRF)*.**
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: https://www.nmhealth.org/publication/view/form/2249/ 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 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	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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 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	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 5 of 9 Individuals. Review of the Agency administrative individual case files revealed the following items were not found and/or did not meet the requirement: **Administrative Case File:** **Supported Living Progress Notes/Daily Contact Logs:** • Individual #10 - None found for 7/29/2024, and 8/26/2024. • Individual #13 - None found for 7/3/2024. **Family Living Progress Notes/Daily Contact Logs:** • Individual #3 - None found for 6/2/2024 – 8/31/2024. **Residential Case File:** **Supported Living Progress Notes/Daily Contact Logs:** • Individual #8 - None found for 10/4/2024. *(Date of home visit: 10/7/2024)* • Individual #13 - None found for 10/5/2024. *(Date of home visit: 10/7/2024)*	**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?)***:** →	

stored in agency office files, the delivery site, or with DSP while providing services in the community.	**Family Living Progress Notes/Daily Contact Logs:** • Individual #3 - None found for 10/1 – 7, 2024. *(Date of home visit: 10/8/2024) (Note: When DSP #507 was asked for evidence of progress notes / daily contact logs, they stated, "I haven't completed June, July and August notes either.").*		

Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	Standard Level Deficiency		
NMAC 7.26.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY. **NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS.** Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 6: Individual Service Plan (ISP)** The CMS requires a person-centered service plan for every person receiving HCBS. The DD Waiver's person-centered service plan is the ISP. **6.6 DDSD ISP Template:** The ISP must be written according to templates provided by the DDSD. Both children and adults have designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e., an acknowledgement of receipt of specific information) and other elements depending on the age and status of the individual. The ISP templates may be revised and reissued by DDSD to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDSD and be required for use to better demonstrate required elements of the PCP process and ISP development. **6.6.1 Vision Statements: The long-term vision statement describes the person's major long-term (e.g., within one to three years) life dreams and aspirations in the following areas:** 1. Live, 2. Work/Education/Volunteer,	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 2 of 13 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: **Addendum A**: • Not Found (#6) **ISP Teaching and Support Strategies:** ***Individual #11:*** *TSS not found for the following, Live Outcome Statement / Action Steps:* • "…will prepare a healthy meal."	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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

Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	Condition of Participation Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur 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 7 of 13 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • None found regarding: Live Outcome/Action Step: "…will use visual to identify items that need to be added to the grocery list" for 8/2024. Action step is to be completed 2 times per month. Individual #4 • None found regarding: Live Outcome/Action Step: "…will research low carbohydrates entrees, side dishes or desserts" for 9/2024. Action step is to be completed 1 time per month. • None found regarding: Live Outcome/Action Step: "…will create a list of his 12 favorite low carbohydrate dishes that he helped to prepare" for 9/2024. Action step is to be completed 1 time per month. • None found regarding: Live Outcome/Action Step: "…will assist with cooking or preparing	**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?)*: →	

developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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,	12 low carbohydrate entrees, side or desserts" for 9/2024. Action step is to be completed 1 time per month. Individual #5 • None found regarding: Live Outcome/Action Step: "…will walk to check mail at the mailbox" for 7/2024 - 8/2024. Action step is to be completed 5 times per month. • None found regarding: Live Outcome/Action Step: "…will help sort the mail" for 7/2024 - 8/2024. Action step is to be completed 5 times per month. Individual #8 • None found regarding: Live Outcome/Action Step: "Purchase new items for her room/home" for 7/2024 - 8/2024. Action step is to be completed 1 time per month. Individual #10 • None found regarding: Live Outcome/Action Step: "Choose church activity" for 7/2024 - 9/2024. Action step is to be completed 2 times per month. *Note: Document maintained by the provider was blank.* • None found regarding: Live Outcome/Action Step: "Attend church activity" for 7/2024 - 9/2024. Action step is to be completed 2 times per month. *Note: Document maintained by the provider was blank.* • None found regarding: Live Outcome/Action Step: "Tell others about outing using communication device" for 7/2024 - 9/2024. Action step is to be completed 1 times per month. *Note: Document maintained by the provider was blank.*		

or with DSP while providing services in the community.	**Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #3 • None found regarding: Live Outcome/Action Step: "will choose what snack he would like" for 7/2024 - 9/2024. Action step is to be completed 2 times per week. • None found regarding: Live Outcome/Action Step: "will pack his snack" for 7/2024 - 9/2024. Action step is to be completed 2 times per week. • None found regarding: Live Outcome/Action Step: "will take a picture of his snack" for 7/2024 - 9/2024. Action step is to be completed 2 times per week. • None found regarding: Live Outcome/Action Step: "will create a story to share his progress" for 7/2024 - 9/2024. Action step is to be completed 2 times per month. **Customized In-Home Supports Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #11 • None found regarding: Live Outcome/Action Step: "…will look up diabetic health recipes on the internet using her iPad" for 7/2024 - 9/2024. Action step is to be completed 2 times per month. *Note: Document maintained by the provider was blank.* • None found regarding: Live Outcome/Action Step: "…will prepare a healthy meal" for 7/2024 - 9/2024. Action step is to be completed 2 times per month. *Note: Document maintained by the provider was blank.*		

	Customized Community Supports Data Collection / Data Tracking/Progress with regards to ISP Outcomes: Individual #1 • None found regarding Fun Action Step: "... will take a picture of her favorite recipe" for 8/2024 - 9/2024. Action step is to be completed 2 times per month. • None found regarding Fun Action Step: "... will add the photo to a photo gallery" for 7/2024 and 9/2024. Action step is to be completed 1 time per month. Individual #4 • None found regarding: Work/learn Outcome/Action Step: "… looks into job or volunteer opportunities" for 9/2024. Action step is to be completed 1 time per month. • None found regarding: Work/learn Outcome/Action Step: "… will choose an event or activity" for 9/2024. Action step is to be completed 1 time per month. • None found regarding: Work/learn Outcome/Action Step: "… will participate in an event or activity" for 9/2024. Action step is to be completed 1 time per month. Individual #5 • None found regarding: Fun Outcome/Action Step: "…will participate in the activity" for 7/2024 - 8/2024. Action step is to be completed 3 times per month. • None found regarding: Fun Outcome/Action Step: "…will create and share stories" for 7/2024 - 8/2024. Action step is to be completed 1 time per month.		

Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and	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 6 of 13 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • According to the Live Outcome; Action Step for "…will use visuals to identify items that need to be added to the grocery list" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2024. Individual #4 • According to the Live Outcome; Action Step for "…will research various paths" is to be completed 4 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2024. • According to the Live Outcome; Action Step for "…will try out each path for comfort, practicality, to determine which one he likes" is to be completed 4 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2024.	**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?)*: →	

purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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,	• According to the Live Outcome; Action Step for "…will select three paths he prefers" is to be completed 4 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2024. Individual #8 • According to the Live Outcome; Action Step for "…will place her meal dishes in the sink" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2024. • According to the Live Outcome; Action Step for "…will put her clothing protector in the hamper" is to be completed 4 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2024. Individual #13 • According to the Live, Outcome; Action Step for "…will participate in a Day Trip." is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2024 - 9/2024. • According to the Live, Outcome; Action Step for "…will share photos of his trip." is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2024 - 9/2024. **Family Living Data Collection / Data Tracking/Progress with regards to ISP Outcomes:** Individual #9		

or with DSP while providing services in the community.	• According to the Live Outcome; Action Step for "…will review his visual schedule to see what tasks he needs to complete" is to be completed 5 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2024. • According to the Live Outcome; Action Step for "…will complete task with decreasing levels of prompting" 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 7/2024. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • According to the Fun Outcome; Action Step for "…will take a picture of her favorite recipe" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2024. Individual #3 • According to the Fun Outcome; Action Step for "… will take pictures of the hosted activity" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2024. Individual #8 • According to the Fun Outcome; Action Step for "Participate in social events in the community" is to be completed 4 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2024 - 8/2024.		

	• According to the Fun Outcome; Action Step for "take pictures during event" is to be completed 4 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2024 - 8/2024. Individual #13 • According to the Fun Outcome; Action Step for "…will participate in water activities (swimming)" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2024. • According to the Fun Outcome; Action Step for "…will participate in misc. physical activities (walk, playball, etc)" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2024.		

Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	Based on residential 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 9 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection/Data Tracking / Progress with regards to ISP Outcomes**: Individual #4 • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Live area. **Agency's Outcomes/Action Steps are as follows:** ◦ *"... will research various paths."* ◦ *" ... will try out each path for comfort, practicality, to determine which one he likes."* ◦ *" ... will select three paths he prefers one time."* **Annual ISP (**9/2024 – 8/2025**)** **Outcomes/Action Steps are as follows:** ◦ *" ... will research low carbohydrates entrees, side dishes or desserts."* ◦ *"... will assist with cooking or preparing 24 low -carbohydrate entrees, side dishes or desserts"*	**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?)*: →	

Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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.	◦ *"...will create a list of his 12 favorite low carbohydrate dishes that he helped to prepare one-time."*		

Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	Standard Level Deficiency	Standard Level Deficiency	
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 19 Provider Reporting Requirements: 19.5 Semi-Annual Reporting:** The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports may be requested by DDSD for QA activities. Semi-annual reports are required as follows: 1. DD Waiver Provider Agencies, except AT, EMSP, PRSC, SSE and Crisis Supports, must complete semi-annual. 2. A Respite Provider Agency must submit a semi-annual progress report to the CM that describes progress on the Action Plan(s) and Desired Outcome(s) when Respite is the only service included in the ISP other than Case Management, for an adult age 21 or older. 3. The first semi-annual report will cover the time from the start of the person's ISP year until the end of the subsequent six-month period (180 calendar days) and is due ten calendar days after the period ends (190 calendar days). 4. The second semi-annual report is integrated into the annual report or professional assessment/annual re-evaluation when applicable and is due 14 calendar days prior to the annual ISP meeting. 5. Semi-annual reports must contain at a minimum written documentation of: a. the name of the person and date on each page; b. the timeframe that the report covers; c. timely completion of relevant activities from ISP Action Plans or clinical service	Based on record review, the Agency did not complete semi-annual reports as required for 1 of 13 individuals receiving Living Care Arrangements and Community Inclusion. **Supported Living Semi-Annual Reports:** • Individual #10 - None found for 4/2024 – 10/2024. *(Term of ISP 4/2024- 4/2025).* **Customized Community Supports Semi-Annual Reports:** • Individual #10 - None found for 4/2024 – 10/2024. *(Term of ISP 4/2024- 4/2025).*	**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?)*: →	

goals during timeframe the report is covering; d. a description of progress towards Desired Outcomes in the ISP related to the service provided; e. a description of progress toward any service specific or treatment goals when applicable (e.g., health related goals for nursing); f. significant changes in routine or staffing if applicable; g. unusual or significant life events, including significant change of health or behavioral health condition; h. the signature of the agency staff responsible for preparing the report; and i. any other required elements by service type that are detailed in these standards. 6. Semi-annual reports must be distributed to the IDT members when due by SComm. 7. Semi-annual reports can be stored in individual document storage. **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.			

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. 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 Eff 11/1/2023 rev. 12/2023 **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,	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 5 of 9 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: **Annual ISP:** • Not Found (#8) • Not Current (#4, 5) **Healthcare Passport:** • Not Found (#8) **Comprehensive Aspiration Risk Management Plan:** • Not Current (#5, 13) **Health Care Plans:** • Falls (#2) • Hospice Palliative Care (#8) • Infection Control (#8)	**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?)*: →	

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 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	Standard Level Deficiency	
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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.	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 1 of 9 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 Current (#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?)*: →	

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 Eff 11/1/2023 rev. 12/2023 **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)***	Based on record review, the Agency did not ensure Orientation and Training requirements were met for 3 of 53 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 (#533) **CPR:** • Not Found (#533) **Assisting with Medication Delivery:** • Not Found (#503, 532)	**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	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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 additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must	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 2 of 11 Direct Support Professional. **When DSP were asked to give examples of Exploitation, the following was reported:** • DSP #518 stated, "That is treating an individual unfairly. Like treating one individual fairly and then treating the other individual with an attitude." DSP's response with regards to exploitation. **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 #518 stated "I think she does." According to the Individual Specific Training Section of the ISP the individual does not require a Positive Behavior Support Plan. (Individual #5) **When DSP were asked, if they knew what the Individual's health condition / diagnosis or where the information could be found, the following was reported:** • DSP #518 stated, "One of them is her knee and for the past 12 months, she has had bad diarrhea every day and constantly going to the restroom." Per the Electronic Comprehensive Health Assessment Tool, the Individual additionally has a diagnosis of Down's Syndrome, Hearing loss	**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?)*: →	

successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported…	Hyperlipidemia, Hypothyroidism. (Individual #5) **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:** • DSP #528 stated, "She has a nutritional plan, BMI, and diabetes." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual additionally requires Health Care Plans for, Status of Care/Hygiene. (Individual #11) **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 #518 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, individual is allergic to Sulfa Drugs. (Individual #5)		

Tag # 1A25.1 Caregiver Criminal History Screening *(Modified by IRF)*	Condition of Participation Level Deficiency		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **A. General:** The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978 (Amended) of the act, a care provider's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider] to impose appropriate administrative sanctions and penalties. **B. Exception:** A caregiver or hospital caregiver applying for employment or contracting services with a care provider within twelve (12) months of the caregiver's or hospital caregiver's most recent nationwide criminal history screening which list no disqualifying convictions shall only apply for a statewide criminal history screening upon offer of employment or at the time of entering into a contractual relationship with the care provider. At the discretion of the care provider a nationwide criminal history screening, additional to the required statewide criminal history screening, may be requested. **C. Conditional Employment:** Applicants, caregivers, and hospital caregivers who have	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 documentation indicating Caregiver Criminal History Screening was completed as required for ~~3~~ 2 of 54 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** **Direct Support Professional (DSP):** • #507 – Date of hire 6/15/2020. ~~• #510 – Date of hire 3/26/2024.~~ **Substitute Care/Respite Personnel:** • #547 – Date of hire 6/15/2020. *(The finding for DSP #510 is removed 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?)*: →	

submitted all completed documents and paid all applicable fees for a nationwide and statewide criminal history screening may be deemed to have conditional supervised employment pending receipt of written notice given by the department as to whether the applicant, caregiver or hospital caregiver has a disqualifying conviction. **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **G. Maintenance of Records:** Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:**			

A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection. Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 16 Qualified Provider Agencies:** **16.1 Caregivers Criminal History Screening Program:** The Caregivers Criminal History Screening Program (CCHSP) is essential to the enforcement of the DOH policy of "Zero Tolerance" of Abuse, Neglect and Exploitation (ANE) and to the DHI mission of enhancing the quality of health systems for all New Mexicans… 1. For the purposes of the DD Waiver, the CCHSP applies to any non-licensed person			

whose employment, contractual or volunteer service with a DD Waiver Provider Agency includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that Provider Agency including: a. DSP, Direct Support Supervisors and Service Coordinators for CCS, CIE, Respite, CIHS, and Living Supports (Family Living, Supported Living, and IMLS); b. any unlicensed CMs; c. administrators or operators of facilities who are routinely on site where support is provided; d. any unlicensed providers of SSE; and e. any compensated persons such as employees, contractors, volunteers, and employees of contractors. 2. All non-licensed personnel must obtain a caregiver criminal history screening background check within 20 calendar days of hire (NMAC7.1.9). Provider Agencies must also check the EAR prior to hiring or contracting with an employee (NMAC 7.1.12). 3. Individuals with a disqualifying criminal conviction or who have been placed on the EAR for a substantiation of ANE are not eligible to work as a caregiver or have access to patient/client/resident information or records.			

Tag # 1A26 Employee Abuse Registry *(Upheld by IRF)*	Standard Level Deficiency		
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 3 of 54 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Professional (DSP):** • #520 Date of hire 4/9/2024, completed 7/17/2024. • #536 – Date of hire 6/6/2022, completed 2/1/2024. • #544 – Date of hire 4/29/2019, completed 5/30/2024. *(Findings for DSP #520, 536, 544 are 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?)*: →	

appropriate identifying information required by the registry. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.			

Tag # 1A26.1 Employee Abuse Registry *(Modified by IRF)*	Condition of Participation Level Deficiency		
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other	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 documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for ~~7~~ 5 of 54 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:** **Direct Support Professional (DSP):** • #504 – Date of hire 9/6/2011. • #507 – Date of hire 6/15/2020. ~~• #510 – Date of hire 3/26/2024.~~ • #514 – Date of hire 9/14/2011. ~~• #520 – Date of hire 4/9/2024.~~ • #523 – Date of hire 11/4/2013. **Substitute Care/Respite Personnel:** • #547– Date of hire 6/15/2020 *(Findings for DSP # 510 and 520 are removed 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?)*: →	

appropriate identifying information required by the registry. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.			

Tag # 1A43.1 General Events Reporting: Individual Reporting	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 19 Provider Reporting Requirements: *19.2 General Events Reporting (GER):*** The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Non-compliance with GER requirements may result in DDSD Contract Management actions including but not limited to the imposition of Civil Monetary Penalties. Provider Agency use of GER in Therap is required as follows: 1. DD Waiver Provider Agencies approved to provide Customized In- Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use the GER … 2. The following events must be reported in GER: a. Emergency Room/Urgent Care/Emergency Medical Services b. Falls Without Injury c. Person not eating, drinking or receiving nutritional or hydration support for more than 48 hours d. Injury (including Falls, Choking, Skin Breakdown and Infection) e. Law Enforcement Use f. All Medication Errors	Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by standards for 2 of 13 individuals. **The following events were not reported in the General Events Reporting System as required by policy:** **Individual #2** • Documentation reviewed indicates on 12/9/2023 the Individual was taken to the Emergency Room for chest pain (Emergency Services). No GER was found. • Documentation reviewed indicates on 1/29/2024 the Individual was taken to Urgent Care for a Urinary Tract Infection (Urgent Care). No GER was found. • Documentation reviewed indicates on 8/29/2024 the Individual was taken to Urgent Care for an upper respiratory infection (Urgent Care). No GER was found. • Documentation reviewed indicates on 9/17/2024 the Individual was taken to Emergency Room for foot pain (Emergency Services). No GER was found. **Individual #3** • Documentation reviewed indicates on 1/19/2024 the Individual was taken to the Emergency Room for head swelling (Emergency Services). No GER was found. • Documentation reviewed indicates on 4/26/2024 the Individual was taken to the Emergency Room for back pain (Emergency Services). No GER was 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?)*: →	

g. Medication Documentation Errors h. Missing Person/Elopement **i.** Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission j. PRN Psychotropic Medication k. Restraint Related to Behavior l. Suicide Attempt or Threat 3. Reporting Provider Agencies must have a system in place to enter information into and approve GERs per Appendix B GER Requirements and as identified by DDSD. 4. Each agency that is required to participate in General Event Reporting via Therap should ensure information from the staff and/or individual with the most direct knowledge is part of the report. Provider agencies may use GER reporting for events that are not required at their discretion. When using the GER to report such events, the report must have a modification level that must be low, be entered and approved within two business days of the event. Events that are tracked for internal agency purposes and do not meet reporting requirements per DD Waiver Service Standards must be marked with a notification level of "Low" to indicate that it is being used internal to the provider agency. **Appendix B GER Requirements**			

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 # 1A09 Medication Delivery Routine Medication Administration	**Condition of Participation Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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 MAR online in Therap must be created and used by the DSP.	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 September and October 2024. Based on record review, 2 of 6 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #1 September 2024 As indicated by the Medication Administration Records the individual is to take Omega-3 Gummies 303 mg, (2 gummies, 1 time daily) According to the Physician's Orders, Fish Oil/Gummie Bears is to be taken 4 gummies, 1 time daily. Medication Administration Record and Physician's Orders do not match. As indicated by the Medication Administration Records the individual is to take Preservision AREDS 2 (1 time daily). According to the Physician's Orders, PreserVision AREDS 2 is to be taken 2 times daily. Medication Administration Record and Physician's Orders do not match. Individual #10 September 2024 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:	**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?)*: →	

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; 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.	• Jevity 1.5 cal (1 time daily) – Blank 9/1/2024 (12:00 PM) As indicated by the Medication Administration Records the individual is to take Jevity 1.5 cal, (1 time daily). According to the Physician's Orders, Jevity 1.5 cal is to be taken 3 times daily. Medication Administration Record and Physician's Orders do not match.		

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.			

Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 13 Nursing Services:** **13.3.2.3 Medication Oversight:** Medication Oversight by a DD Waiver nurse is required in Family Living when a person lives with a non-related Family Living provider; and whenever non-related DSP provide AWMD medication supports. 1. The nurse must respond to calls requesting delivery of PRN medications from AWMD trained DSP, non-related Family Living providers. 2. Family Living providers related by affinity or consanguinity (blood, adoption, or marriage) are not required to contact the nurse prior to assisting with delivery of a PRN medication. 3. Medication Oversight is optional if the person lives independently and can self-administer their medication or resides with their related family. If the person resides with their family and it is determined that Medication Oversight is not desired, the family must continue to provide any needed health supports or interventions based on guidance from the Primary Care Practitioner or specialists and all elements of medication administration and oversight are the sole responsibility of the person and their biological family. In addition, for Family Living participants the related family must: a. Communicate as needed any change of condition with the agency nurse. b. The agency is not responsible for providing a monthly MAR unless the family requests it and continually communicates all medication changes to the Provider Agency in a timely manner to ensure accuracy of the MAR. 4. Medication Oversight is not optional if substitute care is provided by DSP who are not related.	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 and interview, the Agency did not maintain documentation of PRN authorization as required by standard for 1 of 6 Individuals. Individual #8 September 2024 No documentation of the verbal authorization from the Agency nurse prior to each administration / assistance of PRN medication was found for the following PRN medication: • Lorazepam 2 mg – PRN – 9/12 (given 1 time)	**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?)*: →	

a. A MAR is required for the substitute care provider to use. b. Biological families (by affinity or consanguinity) are encouraged, but not required to use the MAR. c. DSP who are related families (by affinity or consanguinity) must complete AWMD training.			

Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider	Standard Level Deficiency		
NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS: **A. Duty to report:** **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers. **(2)** All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 18: Incident Management System:** **18.2 ANE Reporting and Evidence Preservation:** The DD Waiver provider who suspects or is aware of ANE, suspicious injury, environmental hazard, or death is ultimately responsible for appropriate reporting. The DD Waiver Provider Agency may be sanctioned in accordance with NMAC 7.1.14.11 for failure to report incidents of ANE, suspicious injury, environmental hazard, or death; for failure to provide or maintain evidence of an existing IMS and employee, subcontractor, or volunteer training; or for failure to adequately protect people from ANE.	Based on interview and observation, the Agency did not report suspected abuse, neglect, or exploitation**,** unexpected and natural/expected deaths; or other reportable incidents as required to the Division of Health Improvement. **As a result of what was observed the following incident(s) was reported:** Individual #12 • A State ANE Report was filed as a result of the following: On 10/8/2024 at 4:18 PM Surveyors arrived at the individual's home to conduct a home visit. When surveyors entered the home there was a strong smell of animal urine. Surveyors asked to look in the refrigerator/freezer. After surveyors observed the refrigerator the individual's mother/provider told surveyors to go to the west end of the mobile home to see the dry food which is stored in an empty bedroom. As the surveyor walked down the hallway toward that bedroom, the smell of urine was a lot stronger. Next to the bedroom of dry goods was a restroom that was dirty and had wet urine on the floor and dirty rags, brownish in color on the counter and on the tub. There was a dirty mop in the bathtub. Surveyors were in the home for approximately 20 minutes. Surveyors reported experiencing burning lips and eyes while in the home which didn't subside for approximately 30 – 45 minutes after leaving the home. Photos of the restroom were documented. Incident report was reported to DHI.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

Tag # 1A31.2 Human Right Committee Composition	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 3 Safeguards: 3.4 *Human Rights Committee:*** Human Rights Committees (HRC) exist to protect the rights and freedoms of all waiver participants through the review of proposed restrictions to a person's rights based on a documented health and safety concern of a severe nature (e.g., a serious, significant, credible threat or act of harm against self, others, or property). HRCs monitor the implementation of certain time-limited restrictive interventions designed to protect a waiver participant and/or the community from harm. An HRC may also serve other functions as appropriate, such as the review of agency policies on the use of emergency physical restraint or sexuality if desired. HRCs are required for all Living Supports (Supported Living, Family Living, Intensive Medical Living Services), Customized Community Supports (CCS) and Community Integrated Employment (CIE) Provider Agencies. 1. HRC membership must include: a. at least one member with a diagnosis of I/DD; b. a parent or guardian of a person with I/DD; c. a health care services professional (e.g., a physician or nurse); and d. a member from the community at large that is not directly associated (currently or within the past three (3) years) with DD Waiver services.	Based on record review and interview, the Agency did not ensure human rights committee consisted of all the required members. **Review of Agency's HRC committee found there was no evidence of the following HRC members:** • *a member from the community at large that is not associated (past or present) with DD Waiver services.*	**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 # 1A33.1 Board of Pharmacy - License	Standard Level Deficiency		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **Display of License and Inspection Reports** The following are required to be publicly displayed: • Current Custodial Drug Permit from the NM Board of Pharmacy • Current registration from the consultant pharmacist • Current NM Board of Pharmacy Inspection Report Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 16 Qualified Provider Agencies:** **16.5 Board of Pharmacy:** All DD Waiver Provider Agencies with service settings where medication administration/assistance to two or more unrelated individuals occurs must be licensed by the Board of Pharmacy and must follow all Board of Pharmacy regulations related to medication delivery including but not limited to: 1. pharmacy licensing; 2. medication delivery; 3. proper documentation and storage of medication; 4. use of a pharmacy policy manual; and 5. holding an active contract with a Pharmacy Consultant.	Based on observation, the Agency did not provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 2 of 8 residences: **Individual Residence:** • Current Custodial Drug Permit from the NM Board of Pharmacy was not found in the residence (#10) • Custodial Drug Permit from the NM Board of Pharmacy was expired in the residence (#8) *Note: The following Individuals share a residence:* • #1, 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?)***:** →	

Tag # LS06 Family Living Requirements	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 10 Living Care Arrangements (LCA) Living Supports Family Living:** **10.3.9.2.1 Monitoring and Supervision:** Family Living Provider Agencies must: 1. Provide and document monthly face-to-face consultation in the Family Living home conducted by agency supervisors or internal service coordinators with the DSP and the person receiving services to include: a. reviewing implementation of the person's ISP, Outcomes, Action Plans, and associated support plans, including HCPs, Health Passport, PBSP, CARMP, Therapy Plans, WDSI; b. scheduling of activities and appointments and advising the DSP regarding expectations and next steps, including the need for IST or retraining from a nurse, nutritionist, therapists or BSC; and c. assisting with resolution of service or support issues raised by the DSP or observed by the supervisor, service coordinator, or other IDT members. 2. Monitor that the DSP implement and document progress of the AT inventory, Remote Personal Support Technology (RPST), physician and nurse practitioner orders, therapy, HCPs, PBSP, BCIP, PPMP, RMP, and CARMPs… **10.3.9.2.1.1 Home Study:** An on-site Home Study is required to be conducted by the Family Living Provider agency initially, annually, and if there are any changes in the home location, household makeup, or other significant event.	Based on record review, the Agency did not complete Home Studies and / or monthly face-to-face visits as required for 1 of 3 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: **Monthly Consultation with the Direct Support Provider and the person receiving services:** • Individual #3 - None found for 11/2024.	**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 # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	Standard Level Deficiency		

Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023
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 emergency evacuation that makes the residence unsuitable for occupancy;
	Based on record review and observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 5 of 8 Living Care Arrangement residences.
	
	Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:
	
	Supported Living Requirements:
	• Poison Control Phone Number (#3, 10)
	
	• Water temperature in home exceeds safe temperature (110^0 F):
	  • Water temperature in home measured 120^0 F (#1, 5)
	
	  • Water temperature in home measured 113^0 F (#3)
	
	  • Water temperature in home measured 116^0 F (#9)
	
	Note: The following Individuals share a residence:
	• #1, 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?)*: →	

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 # LS26 Supported Living Reimbursement	**Standard Level Deficiency**		
NMAC 8.302.2 Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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… **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	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 1 of 6 individuals. Individual #10 June 2024 • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 6/5/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 6/26/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 6/30/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount.	**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?)***:** →	

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.	July 2024 • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 7/4/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 7.5 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 7/8/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 7/9/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 7/10/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 7/23/2024.		

	Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 7/24/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 3 hours, which is less than the required amount. • The Agency billed 1 units of Family Living (T2016 HB-U7) on 7/29/2024. No documentation was found for 7/29/24 to justify the 1 unit billed. August 2024 • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 8/22/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount. • The Agency billed 1 units of Family Living (T2016 HB-U7) on 8/26/2024. No documentation was found for 8/26/24 to justify the 1 unit billed. Individual #13 June 2024 • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 6/3/2024.		

	Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 6/13/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 7 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 6/14/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount. July 2024 • The Agency billed 1 units of Family Living (T2016 HB-U7) on 7/3/2024. No documentation was found for 7/3/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 7/7/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount.		

	• The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 7/11/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 7/17/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 7/18/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 7/23/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 7 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 7/26/2024.		

	Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 7 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 7/27/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 7/31/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 7 hours, which is less than the required amount. August 2024 • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 8/1/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 8/4/2024. Documentation received accounted for .5 units. As indicated by the DDW		

	Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 8/6/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 8/13/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 9 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 8/18/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 9 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 8/21/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 9 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received		

	accounted for 7 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 8/27/2024. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 9 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 7 hours, which is less than the required amount.		

Tag # LS27 Family Living Reimbursement	Standard Level Deficiency		
NMAC 8.302.2 Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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… **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.	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Family Living Services for 1 of 3 individuals. Individual #3 June 2024 • The Agency billed 1 unit of Family Living (T2033 HB) on 6/2/2024. No documentation was found on 6/2/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/3/2024. No documentation was found on 6/3/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/4/2024. No documentation was found on 6/4/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/5/2024. No documentation was found on 6/5/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/6/2024. No documentation was found on 6/6/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/7/2024. No documentation was found on 6/7/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/8/2024. No documentation was found on 6/8/2024 to justify the 1 unit billed.	**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?)*: →	

21.9 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.	• The Agency billed 1 unit of Family Living (T2033 HB) on 6/9/2024. No documentation was found on 6/9/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/10/2024. No documentation was found on 6/10/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/11/2024. No documentation was found on 6/11/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/12/2024. No documentation was found on 6/12/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/13/2024. No documentation was found on 6/13/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/14/2024. No documentation was found on 6/14/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/15/2024. No documentation was found on 6/15/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/16/2024. No documentation was found on 6/16/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/17/2024. No		

	documentation was found on 6/17/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/18/2024. No documentation was found on 6/18/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/19/2024. No documentation was found on 6/19/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/20/2024. No documentation was found on 6/20/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/21/2024. No documentation was found on 6/21/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/22/2024. No documentation was found on 6/22/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/23/2024. No documentation was found on 6/23/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/24/2024. No documentation was found on 6/24/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/25/2024. No documentation was found on 6/25/2024 to justify the 1 unit billed.		

	• The Agency billed 1 unit of Family Living (T2033 HB) on 6/26/2024. No documentation was found on 6/26/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/27/2024. No documentation was found on 6/27/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/28/2024. No documentation was found on 6/28/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/29/2024. No documentation was found on 6/29/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 6/30/2024. No documentation was found on 6/30/2024 to justify the 1 unit billed. *(Note: During the administrative review of daily notes to justify billing, no documentation was found for 6/2 – 30, 2024. During the residential visit on 10/8/2024, DSP #547 reported that she had not completed her notes and was working on it, as she usually completes them at the end of the month. Then DSP #547 contacted DSP #507, who stated, "I haven't completed June, July and August notes either." Per DDW Standards and Medicaid Billing requirements, "DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing..." Based on evidence found the agency billed for and were paid for services without comprehensive documentation of direct service delivery).*		

	July 2024 • The Agency billed 1 unit of Family Living (T2033 HB) on 7/1/2024. No documentation was found on 7/1/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 7/2/2024. No documentation was found on 7/2/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 7/3/2024. No documentation was found on 7/3/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 7/4/2024. No documentation was found on 7/4/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 7/5/2024. No documentation was found on 7/5/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 7/6/2024. No documentation was found on 7/6/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 7/7/2024. No documentation was found on 7/7/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 7/8/2024. No documentation was found on 7/8/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 7/9/2024. No		

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	comprehensive documentation of direct service delivery). August 2024 • The Agency billed 1 unit of Family Living (T2033 HB) on 8/1/2024. No documentation was found on 8/1/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/2/2024. No documentation was found on 8/2/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/3/2024. No documentation was found on 8/3/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/4/2024. No documentation was found on 8/4/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/5/2024. No documentation was found on 8/5/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/6/2024. No documentation was found on 8/6/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/7/2024. No documentation was found on 8/7/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/8/2024. No documentation was found on 8/8/2024 to justify the 1 unit billed.		

	• The Agency billed 1 unit of Family Living (T2033 HB) on 8/9/2024. No documentation was found on 8/9/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/10/2024. No documentation was found on 8/10/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/11/2024. No documentation was found on 8/11/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/12/2024. No documentation was found on 8/12/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/13/2024. No documentation was found on 8/13/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/14/2024. No documentation was found on 8/14/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/15/2024. No documentation was found on 8/15/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/16/2024. No documentation was found on 8/16/2024 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/17/2024. No		

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	Based on evidence found the agency billed for and were paid for services without comprehensive documentation of direct service delivery).		

HEALTH CARE
AUTHORITY

Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
Alex Castillo Smith, Deputy Secretary
Kathy Slater Huff, Deputy Secretary
Kyra Ochoa, Deputy Secretary
Dana Flannery, Medicaid Director

Date:	January 30, 2025
To:	Cheryl Harrison, Area Director
Provider:	Dungarvin New Mexico, LLC
Address:	2309 Renard Place SE Suite# 205
State/Zip:	Albuquerque, New Mexico 87106
E-mail Address:	caharrison@dungarvin.com
CC:	Scott Good, State Director scgood@dungarvin.com Bill Myers, West Region Director bmyers@dungarvin.com Robert Bachicha, Vice President of Operations rbachicha@dungarvin.com
Region:	Northwest (Farmington)
Survey Date:	October 7 - 18, 2024
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Supported Living, Family Living, Customized In-Home Supports; Customized Community Supports
Survey Type:	Routine

Dear Ms. Harrison,

The Division of Health Improvement Quality Management Bureau received and reviewed the documents you submitted for your Plan of Correction. Your Plan of Correction is not closed.

Your Plan of Correction will be considered for closure when a Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections.

The Quality Management Bureau will need to conduct a verification survey to ensure previously cited deficiencies have been corrected and that systemic Quality Improvement and Quality Assurance processes have been effective at sustaining corrections.

If the Verification survey determines survey deficiencies have been corrected and corrective measures have effectively maintained compliance with DDW Standards, your Plan of Correction will be considered for closure.

If the Verification survey identifies repeat deficiencies, the Plan of Correction process will continue and your case may be referred to the Internal Review Committee for discussion of possible civil monetary penalties possible monetary fines and/or other sanctions.

Thank you for your cooperation with the Plan of Correction process.

Sincerely,

Monica Valdez, BS

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