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:	April 8, 2025
To:	Joseph Chavez, Quality Assurance Director
Provider: Address: State/Zip:	Los Lunas Community Program (NMDOH) 1000 Main Street NW Los Lunas, New Mexico 87031
E-mail Address:	joseph.chavez12@doh.nm.gov
CC:	Kathy Lucero, Deputy Director and Interim Administrator
E-Mail Address:	Kathy.Lucero@doh.nm.gov
Region: Survey Date:	Metro March 3 - 14, 2025
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Supported Living, Intensive Medical Living Services; Customized Community Supports, and Community Integrated Employment Services
Survey Type:	Routine
Team Leader:	Gabriella Marquez, MA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Ashley Gueths, BACJ, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Joanna Ramirez, BCJ, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Nicole Devoti, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jennifer Marquez, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Elizabeth Vigil, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Sally Karingada, BS, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Chavez,

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

and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Determination of Compliance:

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

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

The following tags are identified as Condition of Participation Level:

- Tag # 1A09 Medication Delivery Routine Medication Administration

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File
- Tag # 1A32 Administrative Case File: Individual Service Plan Implementation
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*
- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)
- Tag # 1A22 Agency Personnel Competency
- Tag #1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A33.1 Board of Pharmacy – License
- Tag # IS30 Customized Community Supports Reimbursement
- Tag # LS26 Supported 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,

Gabriella Marquez, MA

Gabriella Marquez, MA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	March 3, 2025
Contact:	**Los Lunas Community Program (NMDOH)** Joseph Chavez, Quality Assurance Director **HCA/DHI/QMB** Gabriella Marquez, MA, Team Lead/Healthcare Surveyor
Entrance Conference Date:	March 3, 2025
Present:	**Los Lunas Community Program (NMDOH)** Joseph Chavez, Quality Assurance Director Kathy Lucero, Deputy Director / Interim Administrator Michael Rodriguez, Residential Service Director **HCA/DHI/QMB** Gabriella Marquez, MA, Team Lead/Healthcare Surveyor Jennifer Marquez, Healthcare Surveyor Joanna Ramirez, BCJ, BA, Healthcare Surveyor Ashley Gueths, BACJ, Healthcare Surveyor Nicole Devoti, BA, Healthcare Surveyor Elizabeth Vigil, Healthcare Surveyor Sally Karingada, BS, Healthcare Surveyor Supervisor
Exit Conference Date:	March 14, 2025
Present:	**Los Lunas Community Program (NMDOH)** Michael Rodriguez, Residential Service Director Caitlyn Blaine, Finance Director Joseph Chavez, Quality Assurance Director Kent Montoya, Nurse Director Kathy Lucero, Deputy Director / Interim Administrator **HCA/DHI/QMB** Gabriella Marquez, MA, Team Lead/Healthcare Surveyor Jennifer Marquez, Healthcare Surveyor Joanna Ramirez, BCJ, BA, Healthcare Surveyor Ashley Gueths, BACJ, Healthcare Surveyor Nicole Devoti, BA, Healthcare Surveyor Elizabeth Vigil, Healthcare Surveyor Sally Karingada, BS, Healthcare Surveyor Supervisor **DDSD - Metro Regional Office** Kim Engelhardt, Provider Support Consultant Anne Montoya, Community Inclusion Coordinator Anna Zollinger, Community Inclusion Coordinator
Administrative Locations Visited:	0 *(Administrative portion of survey completed remotely*)
Total Wellness Visits Completed (Individuals Seen):	38
Total Compliance Survey Sample Size:	18

	12 - Supported Living 6 - Intensive Medical Living Services 18 - Customized Community Supports 7 - Community Integrated Employment
Total Compliance Survey Homes Visits	15
❖ Supported Living Homes Visited	11 *Note: The following Individuals share a SL residence:* • #9, 12
❖ Intensive Medical Homes Visited	4 *Note: The following Individuals share an IMLS residence:* • #4, 5 • #13,18
Persons Served Records Reviewed	18
Persons Served Interviewed	13
Persons Served Observed	5 *(Note: 5 Individuals were observed, 2 individuals were sleeping, and 3 individuals chose not to be interviewed)*
Direct Support Professional Records Reviewed	169
Direct Support Professional Interviewed	15
Service Coordinator Records Reviewed	5
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.					

Agency: **Los Lunas Community Program – Metro Region**
Program: Developmental Disabilities Waiver
Service: Supported Living, Intensive Medical Living Services; Customized Community Supports, and Community Integrated Employment Services
Survey Type: Routine
Survey Date: **March 3 - 14, 2025**

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 Administrative Case File (Other Required Documents)	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Records must contain information of concerns related to abuse, neglect or exploitation. 3. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the	Based on record review, the Agency did not maintain a complete case file at the administrative office for 1 of 18 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: **Behavior Crisis Intervention Plan (BCIP):** • Not Found (#6)	**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?)*: →	

Therap web-based system using computers or mobile devices are acceptable. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 6. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 7. The current Client File Matrix found in Appendix A: Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 8. All records must be retained for six (6) years and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.			

Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	Standard Level Deficiency		
NMAC 8.371.5.16 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - IMPLEMENTATION OF THE ISP: The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan. **8.371.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP)** **C.** Outcomes: **(1)** The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP. **(2)** Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver. **E.** Action plans:	Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 18 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Customized Community Supports Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #5 • No Outcomes or DDSD exemption/decision justification found for Customized Community Supports – Group Services. As indicated by NMAC 8.371.5 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver."	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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

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

Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	Standard Level Deficiency		
NMAC 8.371.5.16 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - IMPLEMENTATION OF THE ISP: The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan. **8.371.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP)** **C.** Outcomes: **(1)** The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP. **(2)** Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver. **E.** Action plans:	Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 3 of 18 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 #11 • According to the Fun Outcome; Action Step for "…. will research trip ideas" 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 1/2025 - 2/2025. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #8 • According to the Fun Outcome; Action Step for "…. will watch a movie" 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 12/2024. Individual #11 • According to the Fun Outcome; Action Step for "…. will research trip ideas" is to be completed 1 time per week. Evidence 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?)*: →	

(1) Specific ISP action plans that will assist the individual in achieving each identified, desired outcome shall be developed by the IDT and stated in the ISP. The IDT establishes the action plan of the ISP, as well as the criteria for measuring progress on each action step. **(2)** Service providers shall develop specific action plans and strategies (methods and procedures) for implementing each ISP desired outcome. Timelines for meeting each action step are established by the IDT. Responsible parties to oversee appropriate implementation of each action step are determined by the IDT. **(3)** The action plans, strategies, timelines and criteria for measuring progress, shall be relevant to each desired outcome established by the IDT. The individual's definition of success shall be the primary criterion used in developing objective, quantifiable indicators for measuring progress. Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024	indicated it was not being completed at the required frequency as indicated in the ISP for 1/2025 - 2/2025. Individual #14 • According to the Fun Outcome; Action Step for "... will photograph chosen activities of his choice that he attends" is to be completed 3 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2024 and 2/2025.		

Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Records must contain information of concerns related to abuse, neglect or exploitation. 3. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data,	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 1 of 18 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, not current and/or did not meet the requirement: **ISP Teaching and Support Strategies:** ***Individual #18:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "… will pick an animal to learn about." *TSS not found for the following Live Outcome Statement / Action Steps:* • "… will watch an educational/learning video of the animal selected."	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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

Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Records must contain information of concerns related to abuse, neglect or exploitation. 3. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports,	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 1 of 18 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: **Behavior Crisis Intervention Plan:** • Not Found (#6)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A22 Agency Personnel Competency	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 17 Training Requirements:** **17.9 Individual-Specific Training Requirements:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence. Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. The trainer must observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed	Based on interview, the Agency did not ensure training competencies were met for 1 of 15 Direct Support Professional. **When DSP were asked, what State Agency do you report suspected Abuse, Neglect or Exploitation to, the following was reported:** • DSP #542 stated, "We write out little things and we call the nurse and I'm pretty sure she handles it from there. We talk to our supervisor and then they call the nurse and they report it to keep us anonymous." Staff was not able to identify the State Agency as Division of Health Improvement or Adult Protective Services. **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 #542 stated, "If he does, it should be in there (DSP gestured to the computer) but I don't think he has crazy behaviors. Yeah, I don't see any behavior plans in here." According to the Individual Specific Training Section of the ISP the Individual requires a Positive Behavioral Supports Plan and DSP are required to be trained. (Individual #6) **When DSP were asked, if the Individual had Behavioral Crisis Intervention Plan (BCIP), If have they had been trained on the BCIP**	**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?)*: →	

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 successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported…	**and what does the plan cover, the following was reported:** • DSP #542 stated, "He didn't have a crisis plan when we got trained and all he had was a food plan, his CARMP I think they call it." According to the Individual Specific Training Section of the ISP the individual requires a Behavioral Crisis Intervention Plan and DSP are required to be trained. (Individual #6) **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 #542 stated, "Food, no. Medication, I'm pretty sure no." As indicated by the Electronic Comprehensive Health Assessment and the Individual Specific Training section of the ISP, the individual is allergic to cake frosting. (Individual #6)		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag #1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 3 Safeguards: 3.1 Decisions about Health Care or Other Treatment: Decision Consultation Process:** There are a variety of approaches and available resources to support decision making when desired by the person. The decision consultation process assists participants and their health care decision makers to document their decisions. It is important for provider agencies to communicate with guardians to share with the Interdisciplinary Team (IDT) Members any medical, behavioral, or psychiatric information as part of an individual's routine medical or psychiatric care. **3.1.1 Decision about Health Care or Other Treatment Decision Consultation:** Decisions are the sole domain of waiver participants; their guardians or healthcare decision makers and decisions can be made that are compatible with their personal and cultural values. Provider Agencies and Interdisciplinary Teams (IDTs) are required to support the informed decisions made by supporting access to medical consultation, information, and other available resources according to the following: The Decision Consultation Process (DCP) is documented on the Decision Consultation Form (DCF) and is used for recommendations when a person or his/her guardian/healthcare decision maker has concerns, needs more information, or has decided not to follow all or part of a	Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations specified by a licensed physician for 1 of 18 individuals receiving Living Care Arrangements and Community Inclusion. Review of the Agency administrative individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Fecal Immunochemical Test:** • Individual #3 - As indicated by collateral documentation reviewed, the test was completed on 8/5/2024. No evidence of test results 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?)*: →	

recommendation from a professional or clinician…			

Tag # 1A09 Medication Delivery Routine Medication Administration	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 10 Living Care Arrangements (LCA): 10.3.5 Medication Assessment and Delivery:** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training; 2. the nursing and DSP functions identified in the Chapter 13.3 Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20 5.7 Medication Administration Record (MAR) **Chapter 20 Provider Documentation and Client Records: 20.5.7 Medication Administration Record (MAR):** Administration of medications apply to all provider agencies of the following services: living supports, customized community supports, community integrated employment, intensive medical living supports. 1. Primary and secondary provider agencies are to utilize the Medication Administration Record (MAR) online in Therap. 2. Medication/Treatment must be recorded online per assisting with medication delivery per the DDSD Assisting with Medication Delivery (AWMD) program. 3. Family Living Providers may opt not to use MARs if they are the **sole** provider who supports the person and are related by affinity or consanguinity. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, a	After an analysis of the evidence it has been determined the following finding resulted in a negative outcome. Medication Administration Records (MAR) were reviewed for the months of February and March 2025. Based on record review, 3 of 18 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #9 February 2025 As indicated by the Medication Administration Records the individual is to take Therapeutic-M 0.4 - 250mg (1 time daily). According to the Physician's Orders, Therapeutic-M 9mg - 400mcg is to be taken 1 time daily. Medication Administration Record and Physician's Orders do not match. Individual #12 February 2025 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Lactaid Fast Act 9,000 Unit (3 times daily) – Blank 2/28 (4:00 PM) • Lactulose 10GM/15ML (1 time daily) – Blank 2/28 (4:00 PM) As indicated by the Medication Administration Records the individual is to take Therapeutic-M 0.4 - 250mg (1time daily). According to the Physician's Orders, Therapeutic-M 9mg - 400mcg is to be taken 1 time daily.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

MAR online in Therap must be created and used by the DSP. 4. Provider Agencies must configure and use the MAR when assisting with medication. 5. Provider Agencies Continually communicate any changes about medications and treatments between Provider Agencies to assure health and safety. 6. Provider agencies must include the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed. b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine and PRN medications and other treatments; all over the counter (OTC) or "comfort" medications or treatments; all self-selected herbal preparation approved by the prescriber, and/or vitamin therapy approved by prescriber. c. Documentation of all time limited or discontinued medications or treatments. d. The initials of the person administering or assisting with medication delivery. e. Documentation of refused, missed, or held medications or treatments. f. Documentation of any allergic reaction that occurred due to medication or treatments. g. For PRN medications or treatments including all physician approved over the counter medications and herbal or other supplements: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the	Medication Administration Record and Physician's Orders do not match. As indicated by the Medication Administration Records the individual is to take Sertraline HCL 200 mg (1 time daily). According to the Physician's Orders, Olanzapine 20 mg is to be taken 1 time daily every night. Medication Administration Record and Physician's Orders do not match. Individual #14 February 2025 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Gabapentin 300 MG (3 times daily) – Blank 2/28 (12:00 PM)		

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.			

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 Orig. Issue:11/1/2021 Reissue eff. 7.1.2024	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 1 of 15 residences: **Individual Residence:** • Current Custodial Drug Permit from the NM Board of Pharmacy was not found in the residence (#16)	**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?)*: →	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**		
NMAC 8.302.2 BILLING FOR MEDICAID SERVICES Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 21: Billing Requirements; 23.1 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and 3. Details of the services provided. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports services for 5 of 18 individuals. Individual #3 December 2024 • The Agency billed 8 units of Customized Community Supports (H2021 HB U1) on 12/4/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 12/4/2024. • The Agency billed 13 units of Customized Community Supports (T2021 HB U9) on 12/18/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 12/18/2024. Individual #4 January 2025 • The Agency billed 18 units of Customized Community Supports (T2021 HB U5) on 1/15/2025. Documentation received accounted for 14 units. Individual #9 December 2024 • The Agency billed 22 units of Customized Community Supports (T2021 HB U5) on 12/30/2024. Documentation received accounted for 14 units.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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. **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.	Individual #11 November 2024 • The Agency billed 10 units of Customized Community Supports (H2021 HB U1) on 11/1/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 11/1/2024. • The Agency billed 8 units of Customized Community Supports (H2021 HB U1) on 11/3/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 11/8/2024. • The Agency billed 3 units of Customized Community Supports (H2021 HB U1) on 11/5/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 11/5/2024. • The Agency billed 9 units of Customized Community Supports (H2021 HB U1) on 11/6/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 11/6/2024. • The Agency billed 13 units of Customized Community Supports (H2021 HB U1) on 11/8/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 11/8/2024. • The Agency billed 4 units of Customized Community Supports (H2021 HB U1) on 11/10/2024. Documentation received accounted for 0 units as services were		

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.	provided concurrently with another service on 11/10/2024. • The Agency billed 14 units of Customized Community Supports (H2021 HB U1) on 11/11/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 11/11/2024. • The Agency billed 16 units of Customized Community Supports (H2021 HB U1) on 11/14/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 11/14/2024. • The Agency billed 18 units of Customized Community Supports (H2021 HB U1) on 11/16/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 11/16/2024. • The Agency billed 14 units of Customized Community Supports (H2021 HB U1) on 11/17/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 11/17/2024. • The Agency billed 6 units of Customized Community Supports (H2021 HB U1) on 11/18/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 11/18/2024. • The Agency billed 8 units of Customized Community Supports (H2021 HB U1) on 11/22/2024. Documentation received accounted for 0 units as services were		

	provided concurrently with another service on 11/22/2024. • The Agency billed 29 units of Customized Community Supports (H2021 HB U1) on 11/25/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 11/25/2024. • The Agency billed 8 units of Customized Community Supports (H2021 HB U1) on 11/29/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 11/29/2024. • The Agency billed 22 units of Customized Community Supports (H2021 HB U1) on 11/30/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 11/30/2024. December 2024 • The Agency billed 21 units of Customized Community Supports (H2021 HB U1) on 12/2/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 12/2/2024. • The Agency billed 16 units of Customized Community Supports (H2021 HB U1) on 12/6/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 12/6/2024. • The Agency billed 8 units of Customized Community Supports (H2021 HB U1) on 12/8/2024. Documentation received		

	accounted for 0 units as services were provided concurrently with another service on 12/8/2024. • The Agency billed 20 units of Customized Community Supports (H2021 HB U1) on 12/9/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 12/9/2024. • The Agency billed 20 units of Customized Community Supports (H2021 HB U1) on 12/12/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 12/12/2024. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 12/13/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 12/13/2024. • The Agency billed 15 units of Customized Community Supports (H2021 HB U1) on 12/15/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 12/15/2024. • The Agency billed 20 units of Customized Community Supports (H2021 HB U1) on 12/16/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 12/16/2024. • The Agency billed 14 units of Customized Community Supports (H2021 HB U1) on 12/20/2024. Documentation received		

	accounted for 0 units as services were provided concurrently with another service on 12/20/2024. • The Agency billed 8 units of Customized Community Supports (H2021 HB U1) on 12/22/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 12/22/2024. • The Agency billed 15 units of Customized Community Supports (H2021 HB U1) on 12/23/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 12/23/2024. • The Agency billed 14 units of Customized Community Supports (H2021 HB U1) on 12/27/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 12/27/2024. • The Agency billed 12 units of Customized Community Supports (H2021 HB U1) on 12/29/2024. Documentation received accounted for 0 units as services were provided concurrently with another service on 12/29/2024. January 2025 • The Agency billed 11 units of Customized Community Supports (H2021 HB U1) on 1/3/2025. Documentation received accounted for 0 units as services were provided concurrently with another service on 1/3/2025. • The Agency billed 15 units of Customized Community Supports (H2021 HB U1) on		

	1/6/2025. Documentation received accounted for 0 units as services were provided concurrently with another service on 1/6/2025. • The Agency billed 2 units of Customized Community Supports (H2021 HB U1) on 1/10/2025. documentation received accounted for 0 units as services were provided concurrently with another service on 1/10/2025. • The Agency billed 9 units of Customized Community Supports (H2021 HB U1) on 1/12/2025. Documentation received accounted for 0 units as services were provided concurrently with another service on 1/12/2025. • The Agency billed 3 units of Customized Community Supports (H2021HB U1) on 1/13/2025. Documentation received accounted for 0 units as services were provided concurrently with another service on 1/13/2025. • The Agency billed 4 units of Customized Community Supports (H2021 HB U1) on 1/17/2025. Documentation received accounted for 0 units as services were provided concurrently with another service on 1/17/2025. • The Agency billed 16 units of Customized Community Supports (H2021 HB U1) on 1/19/2025. Documentation received accounted for 0 units as services were provided concurrently with another service on 1/19/2025. • The Agency billed 4 units of Customized Community Supports (H2021 HB U1) on		

	1/23/2025. Documentation received accounted for 0 units as services were provided concurrently with another service on 1/23/2025. • The Agency billed 10 units of Customized Community Supports (T2021 HB U9) on 1/23/2025. Documentation received accounted for 0 units as services were provided concurrently with another service on 1/23/2025. • The Agency billed 12 units of Customized Community Supports (H2021 HB U1) on 1/26/2025. Documentation received accounted for 0 units as services were provided concurrently with another service on 1/26/2025. • The Agency billed 12 units of Customized Community Supports (H2021 HB U1) on 1/27/2025. Documentation received accounted for 0 units as services were provided concurrently with another service on 1/27/2025. Individual #13 November 2024 • The Agency billed 28 units of Customized Community Supports (T2021 HB U5) on 11/14/2024. Documentation received accounted for 24 units as services were provided concurrently with another service on 11/14/2024. • The Agency billed 12 units of Customized Community Supports (T2021 HB U5) on 11/21/2024. Documentation received accounted for 8 units as services were provided concurrently with another service on 11/21/2024.		

	• The Agency billed 38 units of Customized Community Supports (T2021 HB U5) on 11/28/2024. Documentation received accounted for 34 units as services were provided concurrently with another service on 11/28/2024. December 2025 • The Agency billed 12 units of Customized Community Supports (T2021 HB U5) on 12/5/2024. Documentation received accounted for 8 units as services were provided concurrently with another service on 12/5/2024. • The Agency billed 12 units of Customized Community Supports (T2021 HB U5) on 12/12/2024. Documentation received accounted for 8 units as services were provided concurrently with another service on 12/12/2024. • The Agency billed 26 units of Customized Community Supports (T2021 HB U5) on 12/13/2024. Documentation received accounted for 22 units as services were provided concurrently with another service on 12/13/2024. • The Agency billed 12 units of Customized Community Supports (T2021 HB U5) on 12/19/2024. Documentation received accounted for 8 units as services were provided concurrently with another service on 12/19/2024. • The Agency billed 12 units of Customized Community Supports (T2021 HB U5) on 12/20/2024. Documentation received accounted for 8 units as services were provided concurrently with another service on 12/20/2024.		

Tag # LS26 Supported Living Reimbursement	Standard Level Deficiency		
NMAC 8.302.2 BILLING FOR MEDICAID SERVICES Developmental Disabilities Waiver Service Standards Orig. Issue:11/1/2021 Reissue eff. 7.1.2024 **Chapter 21: Billing Requirements; 23.1 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and 3. Details of the services provided. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer… **21.7 Billable Activities**:	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 3 of 18 individuals. Individual #1 December 2024 • The Agency billed 1 unit of Supported Living (T2016 HB U8) on 12/29/2024. Documentation received accounted for 0.5 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 10.5 hours on 12/29/2024, which is less than the required amount. January 2025 • The Agency billed 1 unit of Supported Living (T2016 HB U8) on 1/5/2025. Documentation received accounted for 0.5 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 10.5 hours on 1/5/2025, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U8) on 1/10/2025. Documentation received accounted for 0.5 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 11 hours on 1/10/2025, which is less than the required amount. Individual #3 November 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?)*: →	

Specific billable activities are defined in the scope of work and service requirements for each DD Waiver service. In addition, any billable activity must also be consistent with the person's approved ISP. **21.9 Billable Units**: The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit, or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units. **21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following: 1. A day is considered 24 hours from midnight to midnight. 2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period. 3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months. **21.9.2 Requirements for Monthly Units:** For services billed in monthly units, a Provider Agency must adhere to the following: 1. A month is considered a period of 30 calendar days. 2. Face-to-face billable services shall be provided during a month where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. **21.9.4 Requirements for 15-minute and hourly units:** For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following:	• The Agency billed 1 unit of Supported Living (T2016 HB U7) on 11/27/2024. Documentation received accounted for 0.5 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 on 11/27/2024, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 11/28/2024. Documentation received accounted for 0(Leave with family) 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 0 hours on 11/28/2024, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 11/29/2024. Documentation received accounted for 0.5 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 on 11/29/2024, which is less than the required amount. Individual #11 December 2024 The Agency billed 1 unit of Supported Living (T2016 HB U6) on 12/17/2024. Documentation received accounted for 0 units. Documentation indicated the Individual was out of the home with family. • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 12/18/2024. Documentation received accounted for 0		

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.	units. Documentation indicated the Individual was out of the home with family.		

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:	May 20, 2025
To:	Joseph Chavez, Quality Assurance Director
Provider: Address: State/Zip:	Los Lunas Community Program (NMDOH) 1000 Main Street NW Los Lunas, New Mexico 87031
E-mail Address:	Joseph.Chavez@doh.nm.gov
CC:	Kathy Lucero, Deputy Director and Interim Administrator
E-Mail Address:	Kathy.Lucero@doh.nm.gov
Region: Survey Date:	Metro March 3 - 14, 2025
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Supported Living, Intensive Medical Living Services; Customized Community Supports, and Community Integrated Employment Services
Survey Type:	Routine

Dear Mr. Joe Chavez:

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

The Plan of Correction process is now complete.

Furthermore, your agency is now determined to be in Compliance with all Conditions of Participation.

To maintain ongoing compliance with standards and regulations, continue to use the Quality Assurance (self-auditing) processes you described in your Plan of Correction.

Consistent use of these Quality Assurance processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies cited in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, for striving to come into compliance with standards and regulations, and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,

Jamie Pond, BS

Jamie Pond, BS
Staff Manager
DHI - Quality Management Bureau