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:	December 18, 2024
To:	Sarah Herrington, Case Manager / Case Manager Supervisor / Case Management Director
Provider: Address: State/Zip:	J&J Home Care, Inc. PO Box 184 Artesia, NM 88211 Artesia, New Mexico 88211
E-mail Address:	Sarahp@jjhc.org
CC:	Jerry Terpening, Board Chair

Board Chair E-Mail Address: jterp@hdc-nm.com

Region: Survey Date:	Southeast November 12 - 22, 2024
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Case Management
Survey Type:	Routine
Team Leader:	Ashley Gueths, BACJ, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Armida Medina, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau; Kayla Benally, BSW, Healthcare Surveyor, Department of Health Improvement/Quality Management Bureau; Sally Rel, MS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Joel Gonzalez, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Kaydee Conticelli, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Herrington,

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:

Compliance: This determination is based on your agency's compliance with Condition of Participation level and Standard level requirements. Deficiencies found only affect a small percentage of the Individuals on the survey sample *(refer to Attachment D for details)*. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File
- Tag # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components
- Tag # 4C02 Scope of Services - Primary Freedom of Choice
- Tag # 4C07 Individual Service Planning (Visions, measurable outcome, action steps)
- Tag # 4C09 Secondary Freedom of Choice (SFOC)
- Tag # 4C12 Monitoring & Evaluation of Services
- Tag # 4C15.1 Service Monitoring: Semi-Annual Reports
- Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian)
- Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office)
- Tag # 4C04 Assessment Activities
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)

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, Marie Passaglia, Plan of Correction Coordinator** at Marie.Passaglia@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, Marie Passaglia at 505-819-7344 or email Marie.Passaglia@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,

Ashley Gueths, BACJ

Ashley Gueths, BACJ
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	November 12, 2024
Contact:	**J&J Home Care, Inc.** Sarah Herrington, Case Manager / Case Manager Supervisor / Case Management Director **HCA/DHI/QMB** Ashley Gueths, BACJ, Team Lead/Healthcare Surveyor
Entrance Conference Date:	November 12,2024
Present:	**J&J Home Care, Inc.** Sara Herrington, Case Manager / Case Manager Supervisor / Case Management Director **HCA/DHI/QMB** Ashley Gueths. BACJ, Team Lead/Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Monica Valdez, BS, Healthcare Surveyor Advanced/ Plan of Correction Coordinator Sally Rel, MS, Healthcare Surveyor Joel Gonzalez, AA, Healthcare Surveyor Kaydee Conticelli, Healthcare Surveyor
Exit Conference Date:	November 22, 2024
Present:	**J&J Home Care, Inc.** Sarah Herrington, Case Manager / Case Manager Supervisor / Case Management Director **HCA/DHI/QMB** Ashley Gueths, BACJ, Team Lead/Healthcare Surveyor Amanda Castaneda, MPA, Healthcare Surveyor Supervisor Armida Medina, Healthcare Surveyor Kayla Benally, BSW, Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor Advanced/ Plan of Correction Coordinator Sally Rel, MS, Healthcare Surveyor Joel Gonzalez, AA, Healthcare Surveyor **DDSD – Southeast Regional Office** Guy Irish, Regional Director
Administrative Locations Visited:	0 *(Administrative portion of survey completed remotely)*
Total Sample Size:	30
Persons Served Records Reviewed	30
Total Number of *Secondary Freedom of Choices* Reviewed:	Number: 125
Case Management Personnel Records Reviewed	12
Case Manager Personnel Interviewed	12

Administrative Interview 1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Individual Medical and Program Case Files, including, but not limited to:
  - Individual Service Plans
  - Progress on Identified Outcomes
  - Healthcare Plans
  - Therapy Evaluations and Plans
  - Healthcare Documentation Regarding Appointments and Required Follow-Up
  - Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry

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, Marie Passaglia at 505-819-7344 or email Marie.Passaglia@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 Marie.Passaglia@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 case management survey the CMS waiver assurances have been grouped into five (5) Service Domains: Plan of Care (Development and Monitoring); Level of Care; Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Assurance system and Medicaid billing and reimbursement processes.)

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

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

Conditions of Participation (CoPs)

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

Service Domains and CoPs for <u>Case Management</u> are as follows:

<u>Service Domain: Plan of Care ISP Development & Monitoring -</u> *Service plans address all participates' assessed needs (including health and safety risk factors) and goals, either by waiver services or through other means. Services plans are updated or revised at least annually or when warranted by changes in the waiver participants' needs.*

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

- **1A08.3 –** Administrative Case File - Individual Service Plan (ISP) / ISP Components
- **4C07 –** Individual Service Planning (Visions, measurable outcome, action steps)
- **4C07.1 –** Individual Service Planning – Paid Services
- **4C10 –** Apprv. Budget Worksheet Waiver Review Form / MAD 046
- **4C12 –** Monitoring & Evaluation of Services
- **4C16 –** Requirements for Reports & Distribution of ISP (Provider Agencies, Individual and/or Guardian)

Service Domain: Level of Care - *Initial and annual Level of Care (LOC) evaluations are completed within timeframes specified by the State.*

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

- **4C04 –** Assessment Activities

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%:

- **1A22/4C02 –** Case Manager: Individual Specific Competencies
- **1A22.1 / 4C02.1 –** Case Manager Competencies: Job Knowledge

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
- **1A15.2 –** Administrative Case File: Healthcare Documentation (Therap and Required Plans)

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/
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRF process, email the IRF Chairperson, Valerie V. Valdez at valerie.valdez@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: **J&J Home Care, Inc. - Southeast Region**
Program: Developmental Disabilities Waiver
Service: Case Management
Survey Type: Routine
Survey Date: **November 12 - 22, 2024**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Plan of Care - ISP Development & Monitoring – *Service plans address all participates' assessed needs (including health and safety risk factors) and goals, either by waiver services or through other means. Services plans are updated or revised at least annually or when warranted by changes in the waiver participants' needs.*			
Tag # 1A08 Administrative Case File	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **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.	Based on record review, the Agency did not maintain a complete client record at the administrative office for 6 of 30 individuals. Review of the Agency individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Positive Behavior Support Plan:** • Not Found (#8) **Speech Therapy Initial / Re-Evaluation Report:** • Initial Evaluation Not Found (#2, 17, 27) **Occupational Therapy Plan *(Therapy Intervention Plan TIP)*:** • Not Found (#24) **Guardianship Documentation:** • Not Found (#11)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

2. Records must contain information of concerns related to abuse, neglect or exploitation. 3. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 6. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 7. The current Client File Matrix found in Appendix A: Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 8. All records must be retained for six (6) years and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.			

Tag # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components	Standard Level Deficiency		
NMAC 8.371.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY. **NMAC 8.371.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS.** **NMAC 8.371.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS.** Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 6: Individual Service Plan (ISP): 6.2 IDT Membership and Meeting Participation:** The Interdisciplinary Team (IDT) membership and meeting participation varies per person. 1. At least the following IDT participants are required to contribute: a. the person receiving services and supports; b. court appointed guardian or parents of a minor, if applicable; c. CM; d. friends requested by the person; e. family member(s) and/or significant others requested by the person; f. DSP who provide the on-going, regular support to the person in the home, work, and/or recreational activities; g. Provider Agency service coordinators; and h. ancillary providers such as the OT, PT, SLP, BSC, nurse and nutritionist, as appropriate; and i. healthcare coordinator… **6.6 DDSD ISP Template**: The ISP must be written according to templates provided by the DDSD. Both children and adults have	Based on record review, the Agency did not maintain a complete client record at the administrative office for 1 of 30 individuals. Review of the Agency individual case files revealed the following items were not found, not current and/or did not meet the requirement: **ISP Signature Page:** • Not Fully Constituted IDT *(No evidence of LCA / CI DSP and Nurse Involvement)* (#20)	**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?)*: →	

designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e., an acknowledgement of receipt of specific information) and other elements depending on the age and status of the individual. **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **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….			

Tag # 4C02 Scope of Services - Primary Freedom of Choice	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **Chapter 1: Initial Allocation and Ongoing Eligibility: 1.4 Primary Freedom of Choice (PFOC):** The applicant completes the PFOC form to select between: 1. An Intermediate Care Facility for Individuals with Intellectual/Developmental Disability (ICF/IID); or 2. The DD Waiver and a Case Management Agency or the Mi Via Self-Directed Waiver and a Consultant Agency. 3. To place their allocation on hold or refuse the allocation: a. The applicant retains their original application date. It is the responsibility of the applicant to contact DDSD at a later date to take the allocation off hold at which time the applicant would be actively awaiting allocation based on their original registration date and available funding; or b. The applicant chooses not to receive services through ICF/IID nor DD Waiver or Mi Via now or in the future. The allocation will be closed, with a notice of rights to an Administrative Fair Hearing, and the applicant would need to re-apply for HCBS with a new application date should they choose to seek services in the future. **Chapter 4 Person Centered Planning (PCP): 4.4 Freedom of Choice of DD Waiver**	Based on record review, the Agency did not maintain documentation assuring individuals obtained all services through the freedom of choice process for 1 of 30 individuals. Review of the Agency individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Primary Freedom of Choice:** • Not Found (#29)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Provider Agencies: People receiving DD Waiver funded services have the right to choose any qualified provider of case management services listed on the PFOC (Primary Freedom of Choice) or CM Agency Change Form and a qualified provider of any other DD Waiver service listed on SFOC (Secondary Freedom of Choice) form. The CM Agency Change Forms are maintained by each Regional Office… **Chapter 9 Transitions:** … In any of these circumstances, appropriate planning must occur, and information must be provided to facilitate a smooth transition and informed choices. The CM plays a critical role in all types of transitions…**9.1 Change in Case Management Agency**: If a person or guardian selects a different case management agency, the following steps must be taken to ensure that critical issues affecting the person's health and safety do not get lost and a complete exchange of information and documentation occurs. 1. The person or guardian has the responsibility to contact their local DDSD Regional Office to complete the CM Agency Change form selecting the new Case Management Agency. 2. When the new Case Management Agency and DDSD receive the CM Agency Change form, file transfers must be completed within 30 calendar days. 3. The transferring Case Management Agency contacts the receiving Case Management Agency to schedule a transition meeting. 4. The transferring Case Management Agency must also inform the DDSD Regional Office(s) of the date and time of the transition meeting. This ensures that the Regional Office(s) are aware of the change and can be available to provide technical assistance as needed.			

Tag # 4C07 Individual Service Planning *(Visions, measurable outcome, action steps)*	Standard Level Deficiency		
NMAC 8.371.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS: Each ISP shall contain**…:** **B. Long term vision:** The vision statement shall be recorded in the individual's actual words, whenever possible. For example, in a long term vision statement, the individual may describe him or herself living and working independently in the community. **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 record review, the Agency did not ensure the ISP was developed in accordance with the rule governing ISP development, for 1 of 30 Individuals. The following was found with regards to ISP: **Individual #24:** • Fun Outcome: "… will walk around and explore her community". Outcome was not measurable, as it did not indicate how and/or when it would be completed.	**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. (4) Provider agencies shall use formats to complete strategies relating to the ISP action plans during or after the IDT meeting. Separate provider agencies working to coordinate specific strategies to achieve the same action plans shall develop their strategies jointly. Service provider agencies shall develop strategies that are clearly integrated and associated with the individual's long term vision, outcomes, action plans and therapy recommendations identified by the IDT. Therapists shall provide input into the development of strategies either directly or through review and revision prior to submission to the case manager. Provider agencies shall submit strategies for inclusion into the ISP to the case manager within two weeks following the ISP meeting. The case manager shall review the strategies for consistency. (5) Supports and services, including services available to the general public, determined by the IDT and indicated in the ISP, shall be			

relevant to the individual's long term vision, desired outcomes and action plans. Supports and services shall be the least restrictive, not unduly intrusive and not excessive in light of the individual's needs. Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 6: Individual Service Plan (ISP):** **6.6.1 Vision Statement:** The long-term vision statement describes the person's major long-term (e.g., within one to three years) life dreams and aspirations in the following areas: 1. Live, 2. Work/Education/Volunteer, 3. Develop Relationships/Have Fun, and 4. Health and/or Other (Optional). **6.6.2 Desired Outcomes:** A Desired Outcome is required for each life area (Live, Work, Fun) for which the person receives paid supports through the DD Waiver. Each service does not need its own, separate outcome, but should be connected to at least one Desired Outcome. Desired outcomes must: 1. be directly linked to a Vision; 2. be meaningful; 3. be measurable; 4. allow for skill building or personal growth; 5. be desired by the person, 6. not contain "readiness traps" or artificial barriers and steps others would not need to complete to pursue desired goals; and 7. not be achievable with little to no effort (e.g., open a savings account or one-time action).			

Tag # 4C09 Secondary Freedom of Choice (SFOC)	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **Chapter 4 Person Centered Planning (PCP): 4.4 Freedom of Choice of DD Waiver Provider Agencies:** People receiving DD Waiver funded services have the right to choose any qualified provider of case management services listed on the PFOC (Primary Freedom of Choice) or CM Agency Change Form and a qualified provider of any other DD Waiver service listed on SFOC (Secondary Freedom of Choice) form. The CM Agency Change Forms are maintained by each Regional Office. **4.4.2 Annual Review of SFOC:** Choice of Provider Agencies must be continually assured. A person has a right to change Provider Agencies if they are not satisfied with services at any time. 1. The SFOC form must be utilized when the person and/or legal guardian wants to change Provider Agencies. 2. The SFOC must be signed at the time of the initial service selection and reviewed annually by the CM and the person and/or guardian… **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….	Based on record review, the Agency did not maintain the Secondary Freedom of Choice documentation (for current services) and/or ensure individuals obtained all services through the Freedom of Choice Process for 7 of 30 individuals. Review of the Agency individual case files revealed 7 out of 125 Secondary Freedom of Choices were not found and/or not agency specific to the individual's current services: **Secondary Freedom of Choice:** • Family Living (#1, 29) • Customized Community Supports (#21, 24, 27) • Speech Therapy (#28) • Adult Nursing Services (#11, 29)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 4C12 Monitoring & Evaluation of Services	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **8.2.7 Monitoring and Evaluating Service Delivery**: The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health, safety and abuse free environment of the person. Monitoring and evaluation activities include the following requirements: 1. The CM is required to meet face-to-face with adult DD Waiver participants at least 12 times annually (one time per month) to bill for a monthly unit. 2. Immediately report any concern of abuse, neglect and exploitation using the established reporting process outlined in Chapter 18.2 ANE Reporting and Evidence Preservation. 3. Parents of children on the DD Waiver must receive a minimum of four visits per year, as established in the ISP. The parent is responsible for monitoring and evaluating services provided in the months case management services are not received. 4. No more than one IDT Meeting per quarter may count as a face-to-face contact for adults living in the community. 5. Face-to-face visits must occur as follows: a. At least one face-to-face visit per quarter shall occur at the person's home.	Based on record review, the Agency did not use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual for 1 of 30 individuals. **Review of the Therap ® Monthly Site Visit Form revealed face-to-face visits were not being completed as required by standard for the following individuals:** **Individual #7** No site visit was noted between 6/2024 - 10/2024. • 6/7/2024 – 11:30 am - 12:00 pm - Home Visit • 7/26/2024 – 11:00 - 11:30am – Home Visit • 8/14/2024- 10 - 10:45am – Home Visit • 9/23/2024 – 9:00 - 9:30am – Home Visit • 10/30/2024 – 2:00 - 2:30pm – Home Visit Per DDW standards, "…at least one face-to-face visit per quarter shall occur at the day program for people who receive CCS and or CIE…"	**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?)*: →	

b. At least one face-to-face visit per quarter shall occur at the day program for people who receive CCS and or CIE in an agency operated facility. c. It is appropriate to conduct face-to-face visits with the person either during times when the person is receiving a service or during times when the person is not receiving a service. d. The CM considers the preferences of the person when scheduling face-to face-visits in advance. e. Face-to-face visits may be unannounced depending on the purpose of the monitoring. **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….			

Tag # 4C15.1 Service Monitoring: Semi-Annual Reports	Standard Level Deficiency		
NMAC 8.371.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: **C.** Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **8.2.7 Monitoring and Evaluating Service Delivery:** The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health, safety	Based on record review, the Agency did not ensure that reports and the ISP met required timelines and included the required contents for 4 of 30 individuals. Review of the Agency individual case files revealed no evidence of semi-annual reports for the following: **Supported Living Semi-Annual Reports:** • Individual #21 – None found for 1/2024 – 5/2024. *(Term of ISP 7/2023 - 7/2024. ISP Meeting held on 5/23/2024).* **Family Living Semi-Annual Reports:** • Individual #15 – None found for 6/2023 – 9/2023. *(Term of ISP 12/2023 – 12/2024. ISP Meeting held on 9/21/2023).* **Customized Community Supports Semi-Annual Reports:** • Individual #15 – None found for 12/2023 - 6/2024. *(Term of ISP 12/2023 – 12/2024).* **Community Integrated Employment Services Semi-Annual Reports:** • Individual #29 – None found for 9/2023 – 3/2024 and 3/2024 - 7/2024. *(Term of ISP 9/2023 - 9/2024. ISP Meeting held on 7/17/2024).* **Nursing Semi - Annual Reports:** • Individual #15 – None found for 6/2023 – 9/2023. *(Term of ISP 12/2023 - 12/2024. ISP Meeting held on 9/21/2023).* • Individual #21 – None found for 1/2024-5/2024. *(Term of ISP 7/2023 - 7/2024. ISP Meeting held on 5/23/2024).*	**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?)***:** →	

and abuse free environment of the person. Monitoring and evaluation activities include the following requirements: **Chapter 19: Provider Reporting Requirements: 19.5 Semi-Annual Reporting:** The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports are required as follows: … 3. The first semi-annual report will cover the time from the start of the person's ISP year until the end of the subsequent six-month period (180 calendar days) and is due ten calendar days after the period ends (190 calendar days). 4. The second semi-annual report is integrated into the annual report or professional assessment/annual re-evaluation when applicable and is due 14 calendar days prior to the annual ISP meeting.	• Individual #25 – None found for 1/2024-7/2024. *(Term of ISP 1/2024 – 1/2025).*		

Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian)	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: 1. CMs will provide complete copies of the ISP to the Provider Agencies listed in the budget, the person and the guardian, if applicable, at least 14 calendar days prior to the start of the new ISP. Copies shall include any related ISP minutes, TSS, IST Attachment A, Addendum A, signature page and revisions, if applicable. 2. CMs will provide complete copies of the ISP to the respective DDSD Regional Offices 14 calendar days prior to the start of the new ISP. **NMAC 8.371.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:** **A.** The case manager shall provide copies of the completed ISP, with all relevant service provider strategies attached, within 14 days of ISP approval to: **(1)** the individual; **(2)** the guardian (if applicable); **(3)** all relevant staff of the service provider agencies in which the ISP will be implemented, as well as other key support persons; **(4)** all other IDT members in attendance at the meeting to develop the ISP; **(5)** the individual's attorney, if applicable; **(6)** others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies; **(7)** for all developmental disabilities Medicaid waiver recipients…, a copy of the completed	Based on record review the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 3 of 30 Individuals: The following was found indicating the agency failed to provide a copy of the ISP to the Provider Agencies, Individual and / or Guardian at least 14 calendar days prior to the start date of the new ISP: **No Evidence found indicating ISP was distributed:** • Individual #15: ISP was not provided to Provider agencies, the individual, and/or guardian. • Individual #17: ISP was not provided to Provider, the individual, and/or guardian. **Evidence indicated ISP was provided after ISP start date:** • Individual #14*:* ISP start date was 3/1/2024, ISP was sent to Individual and / or Guardian on 4/22/2024.	**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?)***:** →	

ISP containing all the information specified in 8.371.5.14 NMAC, including strategies, shall be submitted to the local regional office of the DDSD;.. **B.** Current copies of the ISP shall be available at all times in the individual's records located at the case management agency. The case manager shall assure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.			

Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office)	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: 1. CMs will provide complete copies of the ISP to the Provider Agencies listed in the budget, the person and the guardian, if applicable, at least 14 calendar days prior to the start of the new ISP. Copies shall include any related ISP minutes, TSS, IST Attachment A, Addendum A, signature page and revisions, if applicable. 2. CMs will provide complete copies of the ISP to the respective DDSD Regional Offices 14 calendar days prior to the start of the new ISP. **NMAC 8.371.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:** **A.** The case manager shall provide copies of the completed ISP, with all relevant service provider strategies attached, within 14 days of ISP approval to: **(1)** the individual; **(2)** the guardian (if applicable); **(3)** all relevant staff of the service provider agencies in which the ISP will be implemented, as well as other key support persons; **(4)** all other IDT members in attendance at the meeting to develop the ISP; **(5)** the individual's attorney, if applicable; **(6)** others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies; **(7)** for all developmental disabilities Medicaid waiver recipients…, a copy of the completed ISP containing all the information specified in	Based on record review, the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 4 of 30 Individuals: The following was found indicating the agency failed to provide a copy of the ISP to the respective DDSD Regional Office at least 14 calendar days prior to the start of the new ISP: **No Evidence found indicating ISP was distributed to the regional office:** • Individual #8 • Individual #15 • Individual #17 • Individual #27	**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?)*: →	

8.371.5.14 NMAC, including strategies, shall be submitted to the local regional office of the DDSD;.. **B.** Current copies of the ISP shall be available at all times in the individual's records located at the case management agency. The case manager shall assure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Level of Care – *Initial and annual Level of Care (LOC) evaluations are completed within timeframes specified by the State.*			
Tag # 4C04 Assessment Activities	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **8.2.3 Facilitating Level of Care (LOC) Determinations and Other Assessment Activities:** The CM ensures that an initial evaluation for the LOC is complete, and that all participants are reevaluated for a LOC at least annually….The assessment tasks of the CM include, but are not limited to: 1. Completing, compiling, and/or obtaining the elements of the Long-Term Care Assessment Abstract packet to include: a. a Long-Term Care Assessment Abstract form (MAD 378); b. Client Individual Assessment (CIA); c. a current History and Physical; d. a copy of the Allocation Letter (initial submission only); and e. for children, a norm-referenced assessment. 2. Timely submission of a completed LOC packet for review **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…	Based on record review, the Agency did not complete, compile or obtaining the elements of the Long-Term Care Assessment Abstract packet and / or submitted the Level of Care in a timely manner, as required by standard for 2 of 30 individuals. Review of the Agency individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Level of Care :** • Not Found (#27) **Annual Physical:** • Not Found (#15, 27)	**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 & 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 # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **8.2.7 Monitoring and Evaluating Service Delivery:** The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health, safety and abuse free environment of the person. Monitoring and evaluation activities include the following requirements: … **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…	Based on record review, the Agency did not maintain a complete client record at the administrative office for 2 of 30 individuals. Review of the Agency individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Electronic Comprehensive Health Assessment Tool *(eCHAT) Summary:*** • Not Found (#7) **Aspiration Risk Screening Tool (ARST):** • Not Current (#14)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag #1A12 All Services Reimbursement	**No Deficient Practices Found**		
NMAC 8.302.2 BILLING FOR MEDICAID SERVICES Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 21: Billing Requirements; 23.1 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and 3. Details of the services provided. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer…	Based on record review, the Agency maintained all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving case management for 30 of 30 individuals. *Progress notes and billing records supported Case Management billing activities for the months of July, August, and September 2024.*		

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. **21.9.2 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.			

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:	February 3, 2025
To:	Sarah Herrington, Case Manager / Case Manager Supervisor / Case Management Director
Provider:	J&J Home Care, Inc.
Address:	PO Box 184 Artesia, NM 88211
State/Zip:	Artesia, New Mexico 88211
E-mail Address:	Sarahp@jjhc.org
CC:	Jerry Terpening, Board Chair

Board Chair E-Mail Address: jterp@hdc-nm.com

Region:	Southeast
Survey Date:	November 12 - 22, 2024
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Case Management
Survey Type:	Routine

Dear Ms. Herrington,

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Monica Valdez, BS

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