Date:	December 7, 2016
To:	Brian Conway
Provider:	Professional Home Healthcare, Inc.
Address:	10 Calle Medico
State/Zip:	Santa Fe, New Mexico 87505
E-mail Address:	Brian.conway@phhc-nm.com
CC:	Michelle Esparsen, Director of Operations; Dottie Vargas, Performance Improvement
Email Address:	michelle.esparsen@phhc-nm.com dottie.vargas@phhc-nm.com
Region:	Metro & Northeast
Survey Date:	November 7, 2016
Program Surveyed:	Medically Fragile Waiver
Service Surveyed:	Administrative Review (*Note: At the time of the survey, the agency had no participants receiving reviewed services (Private Duty Nursing, Respite) billed through the Medical Fragile Waiver)*
Survey Type:	Routine Survey
Team Leader:	Corrina Strain BSN RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Conway;

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 Medically Fragile Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider contracts. Upon receipt of this letter and report of findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Plan of Correction:

The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency's 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.

Submission of your Plan of Correction:

Please submit your agency's Plan of Correction in the space on the two right 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, Attention: Amanda Castaneda, Plan of Correction Coordinator 1170 North Solano Suite D Las Cruces, New Mexico 88001**

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.

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:

QMB Deputy Bureau Chief
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request

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 call the Plan of Correction Coordinator, Amanda Castaneda, at 575-373-5716 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,

Corrina Strain BSN, RN

Corrina Strain BSN RN
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	November 7, 2016	
Contact:	**Professional Home Health Care, Inc.** Michelle Esparsen, Director of Operations **DOH/DHI/QMB** Corrina Strain, BSN RN, Team Lead/Healthcare Surveyor	
On-site Entrance Conference Date:	November 7, 2016	
Present:	**Professional Home Health Care, Inc.** Michelle Esparsen, Director of Operations Dottie Vargas, RN Performance Improvement Carol Meserve, RN Director of Nursing Brian Conway, RN Administrator **DOH/DHI/QMB** Corrina Strain, BSN RN, Team Lead/Healthcare Surveyor	
Exit Conference Date:	November 7, 2016	
Present:	**Professional Home Health Care, Inc.** Michelle Esparsen, Director of Operations Dottie Vargas, RN Performance Improvement Brian Conway, RN Administrator **DOH/DHI/QMB** Corrina Strain, BSN RN, Team Lead/Healthcare Surveyor	
Administrative Locations Visited Number:	Number	1
Total Sample Size	Number:	0 (*Note: At the time of the survey, the agency had no participants receiving reviewed services (Private Duty Nursing, Respite) billed through the Medical Fragile Waiver)*
Private Duty Nursing Records Reviewed	Number:	4 (*Full record review not completed only verification of licensure*.)
Administrative Records Reviewed	Number:	3 (*Full record review not completed only verification of licensure*.)
Administrative Personnel Interviewed	Number:	4

Administrative Files Reviewed:

- Accreditation Records
- Internal Incident Management Reports and System Process/ General Events Reports
- Agency Policy and Procedure to include, but not limited to:
    - Transportation policy
    - Tuberculosis Policy and Procedure
    - Rights and Responsibilities and Grievance Policy and Procedures
    - Cultural Sensitivity Policy

- Quality Assurance / Improvement Plan
- Licensure/Certification for Nursing

CC Distribution List: Department Health Improvement (DHI) - File
Developmental Disabilities Support Division (DDSD)
Medical Fragile Program Director
Human Services Department (HSD)
DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
MFEAD – NM Attorney General

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 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.)

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us. 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 to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, 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 Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

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 individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and

5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
6. The POC must be signed and dated by the agency director or other authorized official.

The following details should be considered when developing your Plan of Correction:

- Details about how and when Consumer, Personnel and Residential 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, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc.;
- How accuracy in Billing/Reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how Individual Specific Plans are reviewed to verify they meet requirements, how the timeliness of 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 should 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, Amanda E Castaneda at 575-373-5716 email at AmandaE.Castaneda@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda E. Castaneda, POC Coordinator in any of the following ways:
    a. Electronically at AmandaE.Castaneda@state.nm.us*(preferred method)*
    b. Fax to 575-528-5019, or
    c. Mail to POC Coordinator, 1170 N. Solano Suite D, Las Cruces, NM 88001
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, as follows.

1. Your internal documents are due within a ***maximum*** of 45 business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (scanned and attached to e-mails).
3. All submitted documents ***must be annotated***; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:
    a. Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
    b. Copies of “void and adjust” forms submitted to Xerox State Healthcare, LLC to correct all unjustified units identified and submitted for payment during your internal audit.

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

Attachment C

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

Introduction:

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

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
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: http://dhi.health.state.nm.us/qmb
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, Crystal Lopez-Beck at crystal.lopez-beck@state.nm.us 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 com

Agency: **Professional Home Health Care, Inc. – Metro & NE Regions**
Program: Medically Fragile Waiver Services
Service: Administrative Review
Monitoring Type: Routine Survey
Dates of Survey: **November 7, 2016**

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Administrative Requirements:			
TAG # MF04 **General Provider Requirements**	**Standard Level Deficiency**		
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 **GENERAL PROVIDER REQUIREMENTS** I. Provider Requirements A. The Medicaid Medically Fragile Home and Community Based Services Waiver requires providers to meet any pertinent laws, regulations, rules, policies and interpretive memoranda published by the New Mexico Department of Health (DOH) and HSD. H. The provider agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and that comply with all DDSD policies and procedures and all relevant New Mexico statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed. J. All provider agencies, in addition to requirements under each specific service standard, shall at a minimum develop,	Based on record review and interview the Agency did not ensure that written policies and procedures were reviewed at least every three years and updated as needed. Review of the Agency's policies and procedures revealed the following: **The Agency's Policy and Procedure showed no evidence of the following being reviewed every three years or being updated as needed:** • *Client Rights and Responsibilities* - Dated 06/13/2011; no date found indicating when policy was last reviewed/ revised. • *Emergency Operations Plan* - Dated 8/16/2012; no date found indicating when policy was last reviewed/revised. • *Targeted Tuberculin Testing*- Dated 02/20/13; no date found indicating when policy was last reviewed/revised. • *Client Discharge and Transfer* - Dated 12/19/2013; no date found indicating when policy was last reviewed/revised.	**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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

implement and maintain at the designated provider agency main office, documentation of policies and procedures for the following: 1. Coordination with other provider agency staff serving individuals receiving MFW services that delineates the specific roles of each agency staff. 2. Response to the individual emergency medical situations, including staff training for emergency response and on-call systems as indicated. 3. Agency protocols for disaster planning and emergency preparedness.	• *Cultural Sensitivity* – Dated 09/2009; no date found indicating when policy was last revised/reviewed. **When the Surveyor asked about the reviews and /or revisions on policies, the following was reported:** • #41, stated she would be working on the policies to include updating and revisions as needed.		

TAG # MF103 CQI System	Standard Level Deficiency		
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 **GENERAL PROVIDER REQUIREMENTS:** I. Provider Requirements G. Continuous Quality Management System: 1. On an annual basis, MFW provider agencies shall update and implement the request, the agency will submit a summary of each year's quality improvement activities and resolutions to the MFW Program Manager. **NMAC 7.28.2.39 Requirements for Home Health Agencies - Quality Improvement** Each agency must establish an on-going quality improvement program to ensure an adequate and effective operation. To be considered on-going, the quality improvement program must document quarterly activity that addresses, but is not limited to: **A. Clinical care:** Assessment of patient/client goals and outcome, such as, diagnosis (es), plan of care, services provided, and standards of patient/client care. **B. Operational activities:** Assessment of the total operation of the agency, such as, policies and procedures, statistical data (i.e., admissions, discharges, total visits by discipline, etc.), summary of quality improvement activities, summary of patient/client complaints and resolutions, and staff utilization. **C. Quality improvement action plan:** Written responses to address existing or potential problems which have been identified. **D. Documentation of activities:** The	Based on record review and interview, the Agency did not implement their Continuous Quality Management System as required by standard. Review of the Agency's CQI Plan revealed the following: • The Agency's Continuous Quality Improvement Plan provided during the on-site survey (November 7, 2016) was dated 7/2008. No evidence was found indicating when the document had been updated. • No evidence of the Agency's Continuous Quality Improvement Program quarterly reports /meeting minutes containing statistical data specific to the Medically Fragile Waiver and no evidence of the annual summary of quality improvement activities and resolution to the Medically Fragile Waiver Program Manager. **When the Surveyor asked about the Continuous Quality Improvement Plan, the following was reported:** • #41 stated, she would be working on the policies to include updating and revisions as needed. **When the Surveyor asked if the continuous quality improvement quarterly report/meeting minutes had statistical data specific to Medically Fragile Wavier the following was reported:** • #40 stated, "Due to the agency not having any Medically Fragile Waiver clients with straight Medicaid there has not been a need	**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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

results of the quality improvement activities shall be compiled annually in report format and formally reviewed and approved by the governing body and advisory group of the home health agency. No more than one year may lapse between evaluations of the same part. **E.** The licensing authority may, at its sole discretion, request quarterly activity summaries of an agency's on-going quality improvement activities and/or may direct the agency to conduct specific quality improvement studies. [9/12/74, 8/1/77, 5/7/91, 4/1/97; Recompiled 10/31/01]	to report the QA/QI activities."		

Date: February 7, 2017

To: Brian Conway
Provider: Professional Home Healthcare, Inc.
Address: 10 Calle Medico
State/Zip: Santa Fe, New Mexico 87505

E-mail Address: Brian.conway@phhc-nm.com

CC: Michelle Esparsen, Director of Operations;
Dottie Vargas, Performance Improvement

Email Address: michelle.esparsen@phhc-nm.com
dottie.vargas@phhc-nm.com

Region: Metro & Northeast
Survey Date: November 7, 2016
Program Surveyed: Medically Fragile Waiver

Service Surveyed: Administrative Review (*Note: At the time of the survey, the agency had no participants receiving reviewed services (Private Duty Nursing, Respite) billed through the Medical Fragile Waiver)*

Survey Type: Routine Survey

Dear Mr. Conway;

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 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,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.17.2.MFW. D2062.2&5.RTN.09.17.038