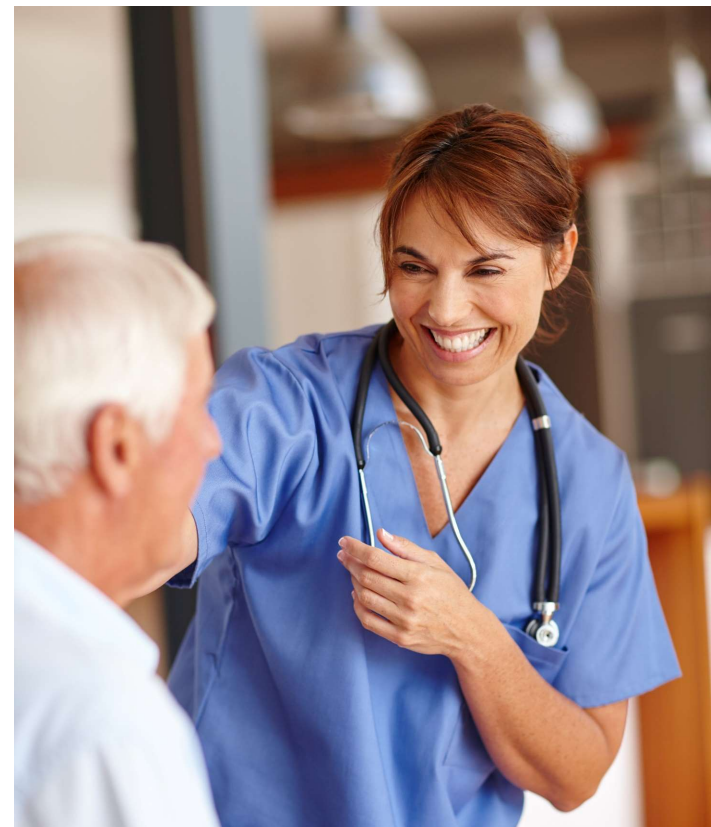




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## NURSING HOME UPDATE 2024

PRESENTED BY

MAURELLA SOOH, DISTRICT OPERATIONS BUREAU CHIEF

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# HEALTH CARE AUTHORITY TRANSITION

- On July 1, 2024, the Division of Health Improvement (DHI) along with Development Disabilities Supports Division (DDSD), Employee Benefits Bureau (EBB), General Services Department (GSD) and the Health Care Affordability Fund combined with the existing Human Services Department to promote:
  - Transparency and clarity about New Mexico's health system performance
  - Oversight and accountability to measure and improve the quality of care and health outcomes
  - Cost-effectiveness and a proactive approach to managing state healthcare funds
  - Customer service through a No Wrong Door approach to healthcare and safety-net programs
  - A unified vision and strategy for healthcare services, coverage and been to delivery to New Mexicans.
- Biggest Changes to DHI:
  - New email address, new letterhead, business cards etc.
  - New Leadership
  - State Regulation References 8.370



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## STATE PERFORMANCE STANDARD SYSTEM (SPSS)

New Mexico SPSS Results 2023	Final Score
S1: Surveys of Nursing Homes SFF	MET
Q1: Focused Concern Surveys	PARTIALLY MET
Q2: Federal Comparative Surveys	N/A
Q3: IDR/IIDR downgrade	MET
S2: NH/ACC Uploads	MET
S3: NH IJ Template	PARTIALLY MET
S4: NH/ACC Overdue Investigations	** (data unavailable)
S5: NH Recertifications	MET



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### (3) Nursing Facilities

## (2) Skilled Nursing Only

29 Long Term Care Surveyors, including (4) Managers and (3) LSC surveyors

8 surveyor vacancies

## 17 SMQT surveyors

Quality Assurance Department, includes Manager, (2) Reviewers, ASPEN Coordinator, Training Coordinator, MDS/OASIS Coordinator

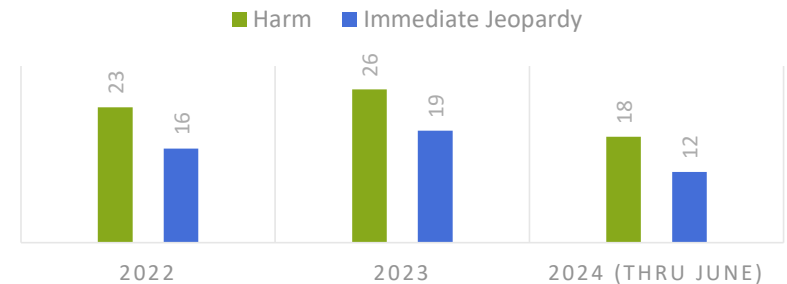
# NURSING HOME DATA FY24 (JULY 1, 2023- JUNE 30, 2024)

State	Avg. # of Deficiencies Recertification Survey {<5/>95 Percentile}	% of Deficiency-Free Surveys {>20%}	% of Surveys Identifying Harm {0-2% or >25%}	% of Surveys Identifying Immediate Jeopardy {0-2% or >10%}	% of Surveys with 4 or More Residents than the Target Sample Size [QS5] {>90 Percentile}	% of Investigations that Led to Citations [QS8] {+/- 1.5 SD}	% of Tags Downgraded or Removed via IDR [QS17] {>40%}	Avg. # of Deficiencies (Standalone Complaint) [QK2] {<0.33 or >1.5}	% of Deficiency-Free Surveys (Standalone Complaint) [QK3] {>80%}	% of Surveys Identifying Harm {<1% or >15%}	% of Surveys Identifying Immediate Jeopardy {<1% or >5%}	Average Number of Days between Survey Start and Survey End (Standalone Complaint) [QK6] {>90 Percentile}	Avg. # of Deficiencies (Complaint with Recerts) [QC2] {<0.33 or >1.5}	% of Deficiency-Free Surveys (Complaint with Recerts) [QC3] {>80%}	% of Surveys Identifying Harm {<1% or >15%}	% of Surveys Identifying Immediate Jeopardy {<1% or >5%}
National	7.43	4.3%	11.5%	4.4%	16.9%	15.8%	23.4%	0.91	60.9%	4.4%	3.1%	1.7	1.83	41.8%	6.3%	3.0%
New Mexico	12.51	0.0%	10.5%	5.3%	61.0%	28.2%	46.9%	1.71	39.5%	8.1%	8.1%	3.2	1.41	29.7%	8.1%	2.7%

- Conducted (215) unannounced onsite surveys (excluding onsite revisits)
  - Complaint Only surveys (147)
  - Recertification surveys (15)
  - Recertification surveys with complaints (44)
  - Licensure Initials/CHOW (9)
  - Investigated (450) complaint assignments
- Cited 1414 health and life safety code deficiencies
  - (262) Life safety code/Emergency Preparedness deficiencies
  - (110) Reporting National Health Safety Network
  - (27) citations identified as causing Harm
  - (18) citations identified at Immediate Jeopardy

- Recertification survey average 120 hours onsite
- Recertification survey with complaints average 166 hours onsite
- Complaint only survey average 28 hours onsite.

## CITATIONS



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0324 - Cooking Facilities	21
0321 - Hazardous Areas - Enclosure	20
0712 - Fire Drills	19
0353 - Sprinkler System - Maintenance and Testing	18
0372 - Subdivision of Building Spaces - Smoke Barrie	15
0521 - HVAC	12
0918 - Electrical Systems - Essential Electric Syste	12
0761 - Maintenance, Inspection & Testing - Doors	11
0007 - EP Program Patient Population	11
0362 - Corridors - Construction of Walls	8
0741 - Smoking Regulations	8
0351 - Sprinkler System - Installation	7
0354 - Sprinkler System - Out of Service	7
0355 - Portable Fire Extinguishers	7

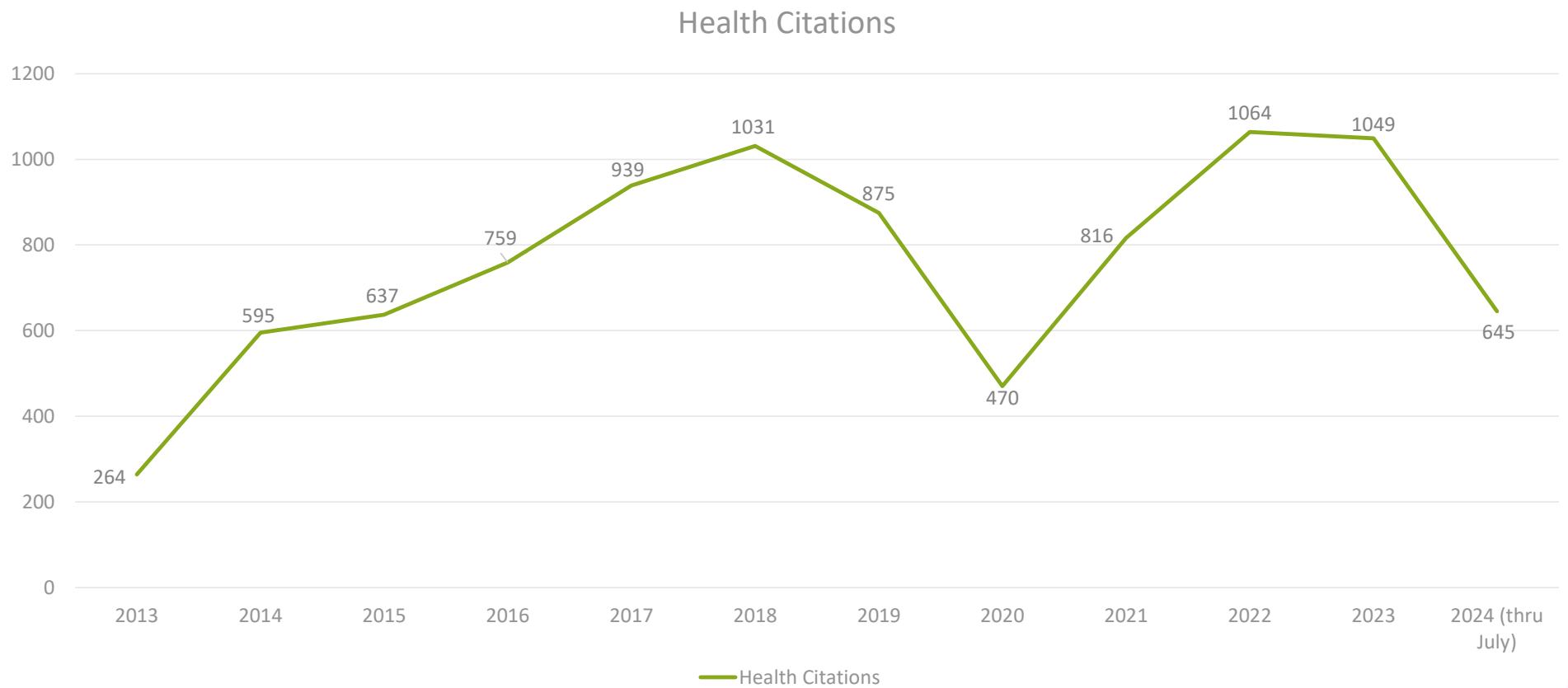
## TOP LIFE SAFETY CODE DEFICIENCIES CITED FY24



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# NEW MEXICO NURSING HOMES



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0884 - Reporting - National Health Safety Network	110
0761 - Label/Store Drugs and Biologicals	47
0657 - Care Plan Timing and Revision	43
0812 - Food Procurement, Store/Prepare/Serve-Sanitary	42
0658 - Services Provided Meet Professional Standards	40
0656 - Develop/Implement Comprehensive Care Plan	34
0684 - Quality of Care	32
0584 - Safe/Clean/Comfortable/Homelike Environment	30
0842 - Resident Records - Identifiable Information	30
0880 - Infection Prevention & Control	27
0689 - Free of Accident Hazards/Supervision/Devices	25
0609 - Reporting of Alleged Violations	20
0758 - Free from Unnec Psychotropic Meds/PRN Use	20
0550 - Resident Rights/Exercise of Rights	19
0580 - Notify of Changes (Injury/Decline/Room, etc.)	17
0623 - Notice Requirements Before Transfer/Discharge	16
0695 - Respiratory/Tracheostomy Care and Suctioning	16

## TOP HEALTH DEFICIENCIES CITED FY24



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# HARM CITATIONS FY24

- **F697- Pain Management (4)**
  - Not providing adequate pain medication for fractured arm.
  - Not providing adequate pain medication. Physician decreased pain medication and resident documented pain 8/10 consistently.
  - Untreated pain for an undiagnosed fracture.
- **F580- Notify of Changes (1)**
  - Resident missed (2) doses of seizure medication and physician not notified resulting in (3) seizures.
- **F600- Free of Abuse and Neglect (5)**
  - Resident with bruising around neck consistent with choking.
  - CNA abused (3) residents. Abuse included significant bruising and swelling to resident's arm from likely being grabbed.
- **F684- Quality of Care (4)**
  - Delay in treatment for resident with significant weight loss and sepsis despite change in vitals
  - Delay in inserting PICC line for resident to receive needed IV antibiotics
  - Resident not eating and drinking for 4 days. Was not sent to ER for evaluation until he became lethargic. Resident later diagnosed with sepsis.
  - Delay in treatment when resident told staff she thought she was having a stroke and had new weakness and wasn't assessed. Several hours later, resident became unresponsive and hypoxic.



- **F686- Treatment/Services to Prevent/Heal Pressure Ulcer (4)**
  - Did not implement new wound care orders likely resulting in worsening of the wound.
  - Not monitoring redness, not implementing preventative interventions, delay in initiating wound treatment after wound discovery and not consistently treating wound as ordered- resulting in wound infection.
  - Not monitoring wound progression, notifying the provider of wound changes and delay in prescribing antibiotics when signs of infection were present.
- **F689- Free of Accident hazards/Supervision/Devices (4)**
  - Bed wheel unlocked, resident fell during bed bath and broke her arm.
  - Resident elopement from unlocked door in kitchen, resulting in frost bite to hands.
  - Resident left alone in the bathroom, fell and sustained a brain bleed.
  - Not assessing resident after fall and delay in sending to ER when resident had a fractured arm.
- **F740- Behavioral Health Services (2)**
  - Resident having mental distress after alleging staff sexual abuse and reliving previous trauma from past relationship. Staff aware of her distress and discussed mental health services but never followed through.
  - Failure to monitor for depressive symptoms or refer for services.
- **F760- Resident are Free of Significant Med Errors (3)**
  - Resident missed (2) doses of seizure medication resulting in (3) seizures.



# IMMEDIATE JEOPARDY CITATIONS FY24

- F609- Reporting of Alleged Violations (1)
  - Staff failed to report allegation of sexual abuse
- F610- Investigate/Prevent/Correct Alleged Violations (2)
  - Failing to thoroughly investigate allegations of abuse.
  - Facility allowed CNA accused of sexual abuse to return to work and he assault another resident.
- F684- Quality of Care (5)
  - Not monitoring diabetic resident blood sugar and did not identify change in condition as related to blood glucose changes
  - Facility did not continue resident diabetic medication from hospital upon admission, did not monitor blood glucose level resulting in a DKA.
  - Not monitoring and treating non-PU wounds.
  - Resident given medication with drug-to-drug interaction, did not monitor potassium levels, did not notify physician of abnormal potassium levels and notify physician of nausea and vomiting likely resulting in resident's death.
  - Not monitoring for constipation resulting in fecal impaction.



- **F686- Treatment/Services to Prevent/Heal pressure Ulcers (1)**
  - Did not provide oversight of skin checks, not accurately document skin impairment, not update and implement preventative measures, treatment and orders resulting in development of unstageable pressure wounds.
- **F689- Free of Accidents Hazards/Supervision/Devices (3)**
  - Resident with hx of grabbing other food, ate food from another resident's plate while staff present and choked and needed to be resuscitated.
  - Leg strap not used during lift transfer resulting in resident fracturing leg.
  - Resident eloped from facility and was found deceased 3 hours later.
- **F726- Competent Nursing Staff (3)**
  - Nurse administered medication to wrong resident
  - Allowed nurse to work without clearance, training and nurse used another nurse's credentials to chart.
- **F760- Residents Free of Significant Med Errors (2)**
  - Resident administered 2 mL (40 mg) of morphine instead of 2 mg. Then did not notify hospital of overdose when resident was transferred.
  - Resident did not receive Eliquis for 7 days resulting in worsening pulmonary embolism.
- **F761- Label/Store Drugs and Biologicals (1)**
  - Not properly storing narcotic medications and disposing of unused and expired medications.



# SURVEY ENFORCEMENT

Termination (6 months) from survey exit

DPNA (90 days) from exit date

ODPNA/DDPNA (15 days) from letter

- Survey exit: last date surveyors were onsite
- Plan of Correction/IDR: 10 calendar days from enforcement
- Remedies:
  - DPNA (90 days from survey exit) versus DDPNA/ODPNA (15 days from date enforcement received for Harm, SQC, IJ)
  - Termination: 6 months from survey exit
- Revisit: Within 60 days of survey exit
  - Enforcement letters to be revised to reflect compliance date within 30 days from enforcement
    - \* Facility determines compliance date on POC



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## THE ENFORCEMENT GRID

**ISOLATED:** One or a very limited number of residents are affected and/or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations.

**PATTERN:** More than a limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice.

**WIDESPREAD:** the problem causing the deficiencies are pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion or all of the facility's residents.

SEVERITY

Immediate Jeopardy To resident health or safety	<b>J</b> Requires Onsite Revisit	<b>K</b> Requires Onsite Revisit	<b>L</b> Requires Onsite Revisit
Actual harm that is not immediate jeopardy	<b>G</b> Requires Onsite Revisit	<b>H</b> Requires Onsite Revisit	<b>I</b> Requires Onsite Revisit
No actual harm with Potential for more than minimal harm that is not immediate jeopardy	<b>D</b> Phone/Fax Revisit	<b>E</b> Phone/Fax Revisit	<b>F</b> Requires Onsite Revisit Only If Substandard Quality of Care (SQC)
No actual harm With potential for minimal harm	<b>A</b>  Does NOT Require A POC. Not on 2567	<b>B</b>  Phone/Fax Revisit	<b>C</b>  Phone/Fax Revisit
	ISOLATED	PATTERN	WIDESPREAD

SCOPE



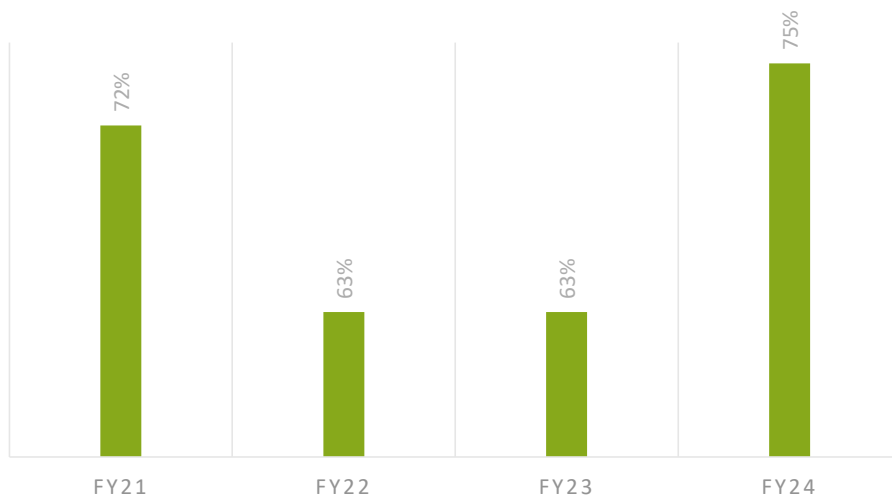
Substantial Compliance

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# ENFORCEMENT CHALLENGES

## PERCENTAGE OF 2567 POSTED WITHIN 10 WORKING DAYS



- Late 2567 Turnaround time: 25%
- Initial Determination: Ability to revise CMS\_2567 reports for up to (1) year
- CMS feedback: wrong Scope/severity and missed IJs
- CMS feedback resulting in 2567 revisions
- Conducting timely revisits
  - 60 days from survey exit
  - Outstanding complaints prior to recert enforcement



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# NURSING HOME CITATIONS DEFENSIBLE FY2024

## Informal Dispute Resolution (IDR)

- 37 Citations disputed
  - (3) Removed during IDR
  - (8) Removed before sending to committee
  - (2) Reduced scope/severity
  - 66% of IDR citations supported
  - MOU w/ Louisiana for IIDR

## CMS Enforcement Review

- (27) Surveys for 22 facilities
- For CMP imposition of
  - (10) IJ Citations
  - (21) Harm Citations
- Surveys supported with CMP; 96%
- IDR removed (1) harm citation
- Resulting in approximately \$611K plus imposed CMPs (minus 35% reduction for waiving appeal)

## CMP Grant Balance (2023): approx. \$3.6 million

ICCNM: Targeted Candida Auris MD Project approx. \$245k  
Long-Term Care Consultants LLC: SNF Clinic approx. \$254k



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# SATISFACTION SURVEY RESULTS FY24

DHI staff:	
Professional/courteous	76% Agree/Strongly Agree
Fair/Unbiased	44% Agree/Strongly Agree
Trained/Knowledgeable	55% Agree/Strongly Agree
Team Leader kept you informed	55% Agree/Strongly Agree

\* 9 Nursing Home responses

- Very respectful and professional
- They were very rude when asking questions
- DHI while interviewing staff, staff was miss quoted on survey results
- Very rude and non-professional
- [name] RN Surveyor was new but doing a great job.
- DHI staff contradicted what they said.
- Surveyors are looking for 100 percent compliance as opposed to substantial compliance
- I think it was fine no need in changing just prefer less people. Yet we understand you are training new staff.
- No notes, great team.
- Overall went well with no concerns
- Not to be so impersonal we are all professional if we are doing something this is not state regulated don't put your personal judgment make sure it's a real tag not something that fits into there perception of the tag.
- Interpret the guidelines appropriately. Perfection is something to strive for but not realistic in this setting. The goal should be to collaborate with facilities not place a barrier in place to make care more challenging.
- Communication was great and they respected our time, allowing us to take care of our residents.
- They were very thorough and approachable. Great with communication.
- Very knowledgeable, in depth survey, always a pleasure to have a team in our facility to make sure we are compliant.
- Very thorough when they enter our building. We appreciate their time and professionalism.
- More training of the surveyors not so robotic.



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# DIFFERENT TYPES OF CMS SURVEYS

## Resource and Support Survey

The Federal Surveyor(s) accompany State Agency (SA) surveyors, on any survey types, to observe and assess the overall SA surveyor team performance and performance related to specific areas of concern

## Focused Concern Survey

Are completed by one or more Federal Surveyor(s) who conduct an independent investigation of the identified concern areas, and surveys selected for FCS can be either a standard survey or complaint survey.

- Are usually completed in the second 6 months of the FY.
- Need to be conducted within 60 calendar days of the SA's survey exit date.
- Includes at least 2 of the identified concern areas for a given state.

## Health Comparative Survey

A full survey conducted by Federal Surveyors in the same facility AFTER a standard survey was conducted by the SA.

- The purpose of the Health Comparative survey is to monitor and evaluate SA performance.
- A LTC Comparative survey should be conducted within 60 calendar days following the SA's standard survey.

## Risk Based Survey (RBS)

- CMS is testing a risk-based survey (RBS) approach that allows consistently higher-quality facilities to receive a more focused survey that takes less time and resources than the traditional standard recertification survey, while ensuring compliance with health and safety standards.
- Higher quality could be indicated by a history of fewer citations for noncompliance, higher staffing, fewer hospitalizations, and other characteristics (e.g., no citations related to resident harm or abuse, no pending investigations for residents at immediate jeopardy for serious harm, compliance with staffing and data submission requirements).
- The number of nursing homes that could meet these criteria would be limited, such as up to 10 percent of nursing homes within a state. The survey resources saved by performing a more focused review of the required areas of a standard survey in these higher quality facilities would then be available to perform more timely oversight of facilities where the risks to residents' health and safety are greater.
- If any concerns about resident safety were encountered during the RBS, it would immediately be expanded. Resident safety will always be prioritized, regardless of the type of survey process. The RBS process would not apply to complaint surveys.



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# SPECIAL FOCUS FACILITY (SFF) CHANGES

- CMS' SFF program requires the persistently poorest performing facilities selected in each state to be inspected no less than once every six months and that increasingly severe (progressive) enforcement actions are taken when warranted. CMS expects that selected facilities will rapidly make and sustain improvements so that they graduate from the program.
- Nursing homes are identified as SFF candidates based on their last three standard health survey cycles and the last three years of complaint survey performance. Each facility is given a numerical score based on the health inspection rating methodology (facilities with the worst scores in a state become candidates).
- CMS will closely monitor graduates from the SFF program for a period of three years to ensure improvements are sustained. For SFFs that graduate but continue to demonstrate poor compliance identified on any survey (e.g., actual harm, substandard quality of care, or immediate jeopardy deficiencies), CMS may use its authority to impose enhanced enforcement options, up to, and including discretionary termination from the Medicare and/or Medicaid programs.

## Graduation From the SFF Program

Two consecutive standard health surveys with 12 or fewer deficiencies cited at scope and severity level (S/S) of "E" or less on each survey.

SFFs will not graduate if the following occurs:

- Any standard health survey results in deficiencies cited at an S/S level of "F" or higher, or
- Any LSC or EP survey resulting in deficiencies cited at an S/S level of "G" or higher; or
- Any survey (standard health, LSC, EP, or complaint) with 13 or more total deficiencies cited on any per survey.
- Intervening complaint surveys with 13 or more total deficiencies, or any deficiencies cited at an S/S level of "F" or higher.

Additionally, an SFF cannot graduate with pending complaint surveys triaged at IJ, or Non-IJ High, or until it has returned to substantial compliance.



**CMS changes/considerations:**

- Long Term Care Staffing Regulations and Promote Nursing.
- Review Civil Monetary Penalty imposition formula for more consistency
- Advocate for Survey and Certification to be a mandatory budget versus discretionary
- Reviewing and revising CMP Grant amount allowances
- Revision to LTCSP and move ASPEN to the cloud

**DHI changes/considerations:**

- Creating Advanced Surveyor positions (certified LSC and Health surveyor)
- Enhance enforcement by implementing more Directed Plan of Corrections, Mandatory Training In-Services, Consultants etc).
- Refer to Nursing Home Compare Data (includes star rating, 3 years of health inspections, staffing rating, quality measures, covid 19 vaccination rates, fire safety inspections and emergency preparedness inspections, penalties imposed and ownership details
- Building an HCA website that includes detail information of NM healthcare facilities (will include licensing information) to improve consumer transparency.

# UPCOMING CHANGES



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# REGULATIONS FOR REPORTING REQUIREMENTS

## STATE REGULATIONS NMAC 8.370.9

8.370.9 NMAC- This regulation establishes standards for **licensed health care facilities** to institute and maintain an incident management system and employee training program for the reporting of allegations of abuse, neglect, misappropriation of property and injuries of unknown origin.

### Duty to Report:

- (2) All licensed health care facilities shall report abuse, neglect, exploitation, and injuries of unknown origin or other reportable incidents to the bureau within a 24-hour period, or the next business day when the incident occurs on a weekend or holiday.
- (3) All licensed health care facilities shall ensure that the reporter with direct knowledge of an incident has immediate access to the bureau incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.

5 day Follow up Investigative Summary Report  
NMAC 8.370.9.10 (C)

Facility follow up investigation is due within 5 business days.

- Facilities should also review the Incident Management Guide for All Licensed Health Care Facilities 2024

## FEDERAL REGULATIONS F609 AND F610

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.



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# REPORTABLE INCIDENT

- 8.370.9.7 V. Reportable incident –
- Possible abuse, neglect, exploitation, injuries of unknown origin and other events but not limited to:
- Falls which cause injury
- Unexpected death
- Elopement
- Medication error which causes or is likely to cause harm
- Failure to follow a doctor's order or an ISP
- Any other incident which may evidence abuse, neglect, or exploitation.
- Environmental Hazards: Water, Electricity, etc.



# FACILITIES/AGENCY EXPECTATIONS

- Improve operational systems/update care plans
  - Establish and maintain an incident management system which emphasizes the principles of prevention and staff involvement.
  - Train staff regularly on how to respond to, report, and document reportable incidents in a timely and accurate manner. (documentation of training)
  - Be transparent with IR and 5-day follow-up
  - Use DOH-DHI as a resource
  - All licensed health care facilities shall post 2 or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and internet addresses. (facilities with 60 or more should have 3 posters)
- WEBSITE:
    - [HTTPS://WWW.HCA.NM.GOV/DIVISION-OF-HEALTH-IMPROVEMENT](https://www.hca.nm.gov/division-of-health-improvement)
  - HOTLINE: 1-800-752-8649
  - FAX: 1-888-576-0012
  - Email: [Incident.Management@hca.nm.gov](mailto:Incident.Management@hca.nm.gov)



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# MDS RESOURCE GUIDE CHANGES

## CMS MDS Change Table

MDS 3.0 Item Set Change History for October 2024

Version 1.18.1

Sections:

### Version 1.19.1 Changes.....

Item Set Documents.....

Section A Items.....

Section B Items.....

Section GG Items.....

Section I Items.....

Section J Items.....

Section N Items.....

Section O Items.....




Contact:  
Cynthia Parsons, BSN, RN  
MDS/Oasis Education Coordinator  
[Cynthia.Parsons@hca.nm.gov](mailto:Cynthia.Parsons@hca.nm.gov)  
(505) 660-4569



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Headmaster LLP

New Mexico Nurse Aide Testing Services

Innovative, quality technology solutions  
throughout the United States  
since 1985.



Headmaster is honored to be approved by the New Mexico Health Care Authority to offer Certified Nurse Aide Testing and Registry Services to the New Mexico Health Care Community.

We look forward to working with everyone involved with Certified Nurse Aide Training, Testing and Registry Services in New Mexico!

**See below: NEW New Mexico Nurse Aide Candidate Handbook available. Effective for testing beginning July 2024. Download it to your smart device!**

Candidates	Training Programs - Test Sites	TEST ADMINISTRATION SERVICES ENTITY (TASE)   RN TEST OBSERVER	Contacts
<b>TestMaster Universe (TMU®)</b> New Mexico TMU® Login  <b>New Mexico Candidate Handbook</b> Effective July 2024 Download it to your smart device!  <b>Knowledge Exam Instructions</b>  <b>Remotely Proctored Knowledge Exam Instructions</b>  <b>Skill Test Instructions</b>	<b>Requesting a Login for TMU®</b> Instructor Login Request  Mock Skills Effective August 2024  How to Complete a Student's Training  How to Incomplete a Student's Training <i>(candidates who do not successfully complete training)</i>  How to Pay Testing Fees <i>(for Training Programs and Sponsoring Facilities)</i>  Training Program Reports <i>(Accessing and Understanding)</i>	<b>TASE-RN TEST OBSERVER APPLICATION</b>  <b>RN TEST OBSERVER/TEST SITE EQUIPMENT LIST</b> <i>(Referenced in the TASE-RN Test Observer Application)</i> Print and keep a copy for your reference.  <b>OTHER TASE-RN TEST OBSERVER FORMS</b> <i>(Attachment A documents referenced in the TASE-RN Test Observer Application)</i>  Test Administration Services Agreement <b>Form TASE FORM 1505NM</b> <i>(Referenced in the TASE-RN Test Observer Application)</i>	Please feel free to contact us if you have questions, concerns, or suggestions about our service. We value the feedback we receive from everyone involved in the New Mexico Nurse Aide training, testing, and certification process. <b>D&amp;S Diversified Technologies - HEADMASTER</b> Naomi Wolfe Program Manager PO Box 6609 Helena, MT 59604  <b>TESTING Questions Toll Free</b> Phone: 888-401-0462 Fax: 406-442-3357  <b>REGISTRY Questions</b> Phone: 888-401-0462  newmexico@hdmaster.com
<b>TestMaster Universe (TMU®) How To Guides CANDIDATES</b> <i>(please refer to the Candidate Handbook for more information)</i> How to Sign In to Your Account and Forgot Your Password/Reset Your Account  How to Complete your Account  How to Schedule or Reschedule for a Test Event  How to Renew your Certification in TMU	<b>Test Sites</b> <b>TEST SITE AGREEMENT APPLICATION</b> Test Site Agreement Form <i>(Referenced in the Test Site Agreement Application)</i>  <b>TEST SITE EQUIPMENT LIST</b>  <b>Fluid Intake Cups</b> FLUID INTAKE CUP ORDER FORM		

# WELCOME HEADMASTER

The State of New Mexico has transitioned to a new vendor for our Certified Nurse Aide Registry.

No more paper applications or paper payments

Everyone needs an active email address for their profile.

Certified Nurse Aide

Training Programs

Employers

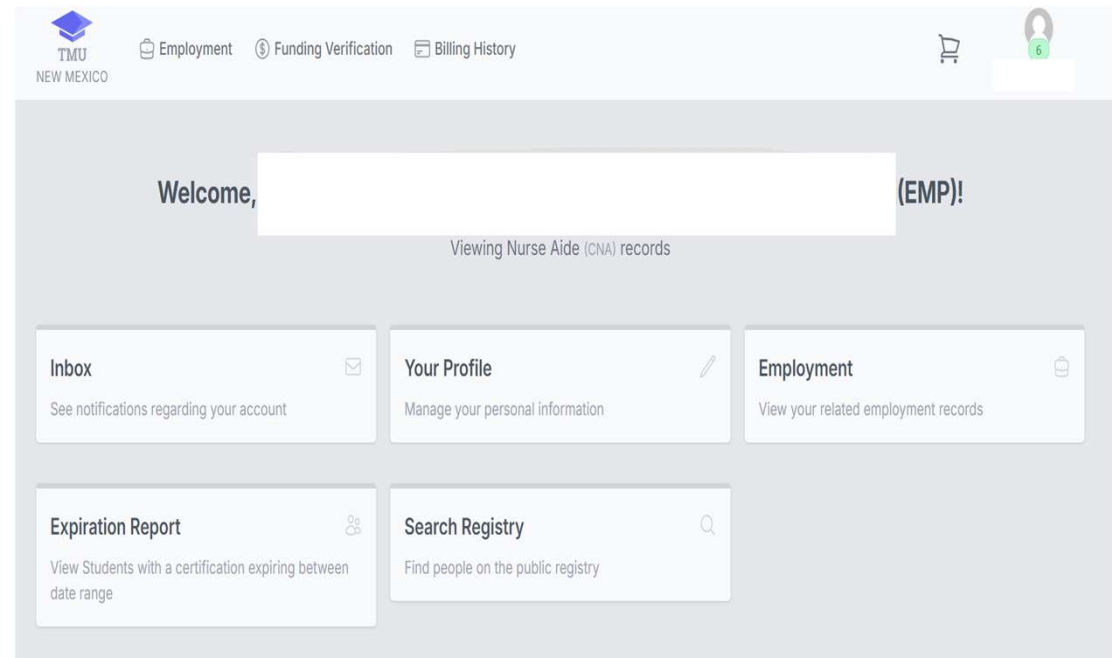


HEALTH CARE  
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Investing for tomorrow, delivering today.

# EMPLOYER PROFILE

- Every active employer in the registry has an employer profile.
  - Update facility information
  - Search the public NM Nurse Aide Registry
  - Generate reports on CNAs set to expire in a specific timeframe
  - Verify your staffs' employment

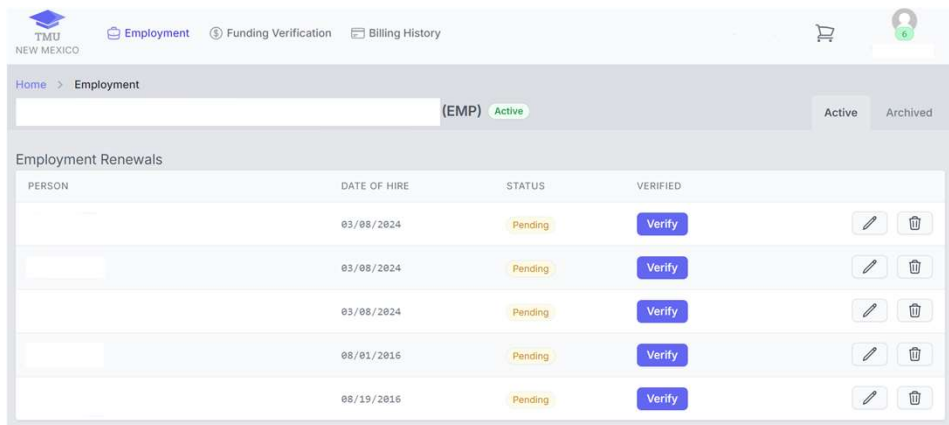


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# EMPLOYMENT VERIFICATIONS

- As an employer that employs CNAs, you will need to provide a point of contact for employment verifications.
  - Name
  - Title
  - Contact number
  - Email address
  
- Only one point of contact per employer however alternative contacts for notification only.



TMU NEW MEXICO

Home > Employment

(EMP) Active

Active Archived

Employment Renewals

PERSON	DATE OF HIRE	STATUS	VERIFIED
	03/08/2024	Pending	Verify
	03/08/2024	Pending	Verify
	03/08/2024	Pending	Verify
	08/01/2016	Pending	Verify
	08/19/2016	Pending	Verify



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# EMPLOYMENT VERIFICATIONS – CONT.

- As an employer, you are verifying that the employee worked as an employee or contracted employee at least 8.00 hours between the dates of hire noted by the employee.
  - Please note the term “contracted employees”
    - If you employee agency CNAs, they most likely will use your facility to verify their employment.
    - Staffing agencies are not approved employers in the registry and cannot approve their own staff.

Employment

PERSON

CERTIFICATION

Nurse Aide

EMPLOYER

(EMP)

START DATE

03/08/2024

END DATE

STATUS \*

Select Status

☐ I verify that , has worked as an employee or contracted employee at least 8.00 hours between 07/23/2011 and 08/31/2024

Complete Verification





ONCE YOU HAVE VERIFIED YOUR STAFF'S  
EMPLOYMENT, THEIR CERTIFICATION WILL  
AUTOMATICALLY BE RENEWED FOR  
ANOTHER 2 YEARS.



IF YOU HAVE NOT ALREADY, PLEASE REACH  
OUT TO THE CNA REGISTRY & TRAINING  
COORDINATOR, VIA EMAIL AT  
[PAMELA.PREDIKA@HCA.NM.GOV](mailto:PAMELA.PREDIKA@HCA.NM.GOV) WITH  
INFORMATION ON YOUR FACILITY'S POINT  
OF CONTACT AS SOON AS POSSIBLE.

# THANK YOU



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THANK YOU!



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