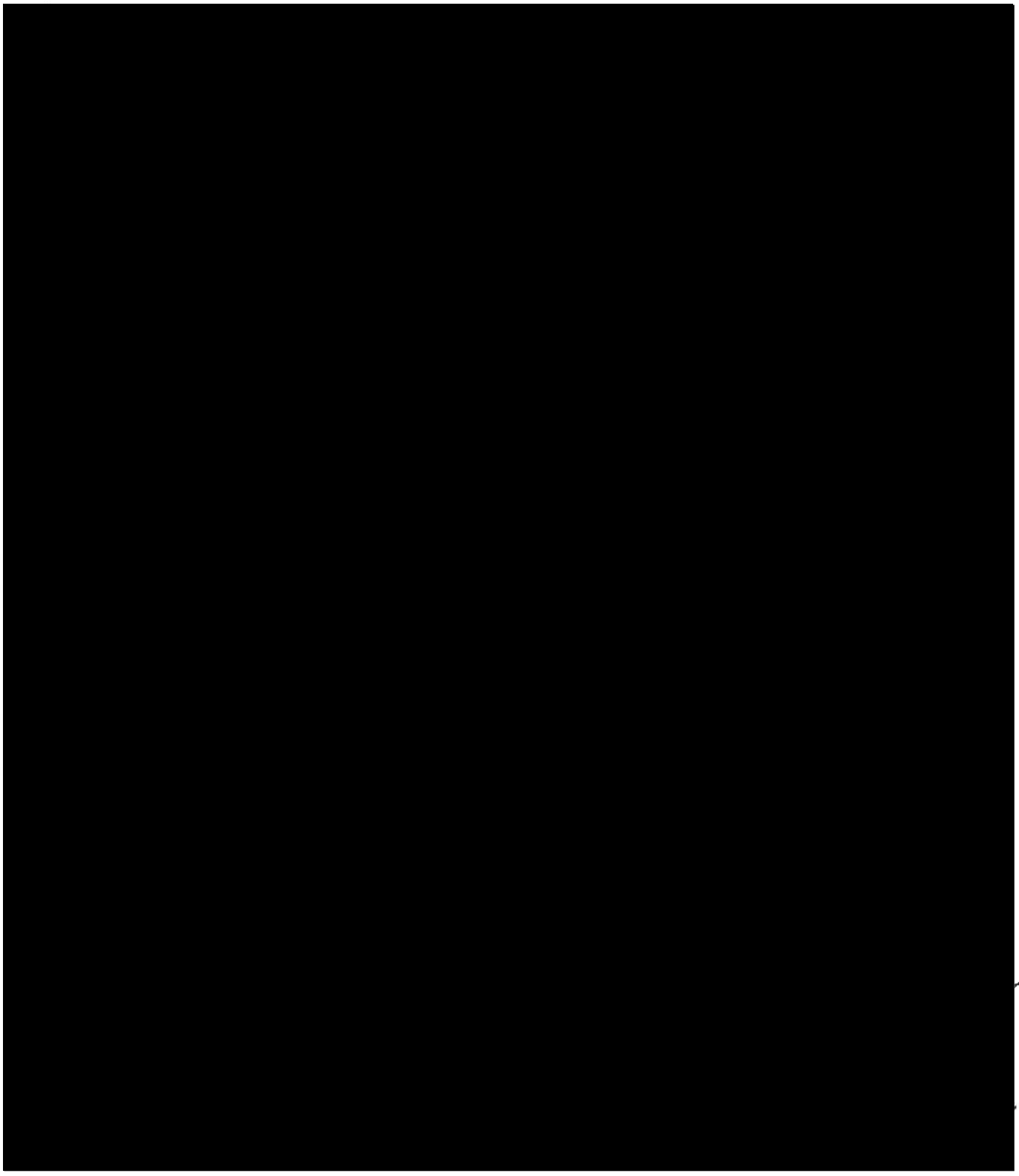

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4102	A. BUILDING: _____ B. WING _____	R-C 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN CARE - COTTONWOOD HOUSE	5305 QUEENS CT NE ALBUQUERQUE, NM 87109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments The following deficiencies were cited during a Follow-Up/Revisit survey completed o[redacted]/23 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living for Adults. Census: [redacted]	{A 000}		
{A 025}	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior;	{A 025}		

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{A 025}	Continued From page 1 (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 B Based on record review and interview, the facility failed to ensure for [redacted] residents whose evaluations were reviewed for compliance, that evaluations were reviewed and updated at a minimum of every six (6) months, or	{A 025}		

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{A 025}	Continued From page 2 when there is a significant change in the resident's health status. These deficient practices could likely result in the residents to be at risk of not getting the care and services needed, if the Direct Care Staff (DCS) do not know what the residents' specific needs are. The findings are: A. Record review of R #3's (admission date: [redacted]22) resident file revealed no evidence that R #3's Resident Evaluation was reviewed and updated at a minimum of every six (6) months. B. On [redacted]23 at 11:18 am, during an interview with the Care Director, she confirmed that R #3's Resident Evaluation was not updated since her last evaluation, dated [redacted]22.	{A 025}	Administrator of the facility will ensure initial evaluation is completed by appropriate staff members up to 15 days of admission, every 6 months and with significant change of condition, and reviewed and signed by an RN, LPN, or Physician extender. Administrators will perform bi-annual audit of resident records to ensure ongoing compliance. R #3 evaluation will be updated by [redacted]-2023,	[redacted]2023
{A 026}	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is	{A 026}		

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{A 026}	Continued From page 3 a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (3) Based on record review and interview, the facility [redacted] to ensure for 2 [redacted] residents whose Individual Service Plans (ISP's) were reviewed for compliance, that they were reviewed and/or revised at a minimum of every six (6) months, or when there is a significant change in the resident's health status. These deficient practices could likely result in the	{A 026}		

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{A 026}	Continued From page 4 residents not receiving appropriate care/services if the ISP's are not current. The finding are: A. Record review of R #1's (admission date: [redacted]19) resident file revealed no documented evidence that the ISP's were reviewed and or revised at a minimum of every six (6) months. The last ISP was dated [redacted]22. B. Record review of R #3's (admission date: [redacted]22) resident file revealed no documented evidence that the ISP's were reviewed and or revised at a minimum of every six (6) months. The last ISP was dated [redacted]22. C. On [redacted]23 at 11:18 am, during an interview with the Care Director, she confirmed that R #1 and R #3's ISP's had not yet been updated.	{A 026}	Administrator of facility will ensure ISP is completed by appropriate staff member within 10 days of admission,,every 6 months, and with significant change of condition and is reviewed and signed by a RN ,LPN, or physician extender utilizing the individual Service Plan Form. Administrator will ensure coordination of care with outside agencies by scheduling care coordination meetings and requiring all representatives to sign the Care coordination form. R #3 ISP will be updated and signed by a RN,LPN,or physician extender.	[redacted]-2023