

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG 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 an Initial survey completed on 12/20/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC. B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant	A 016		

Division of Health Improvement
LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/25/20

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 1 training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 2 7.8.2.16 A (9) B (3) (7) Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry,	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 3 including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006]	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 4 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four (\$74) dollars. Of which, twenty-four (\$24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven (\$7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 5 application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification.	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 6 (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview, the facility failed to ensure that the Administrator and all Direct Care Staff (DCS) were in compliance with the following: 1. Employee Abuse Registry (EAR) inquiries were submitted and clearances received prior to hire by the new facility owner. 2. Submission of the Caregivers Criminal History Screening (CCHSP) applications were submitted within 20 days after hire by the new facility owner. This deficient practice has the potential for all 4 (R #s 1-4) residents listed on the census provided by the Care Director, (CD) on 12/19/19, to be at risk of harm if the Administrator or DCS had a previous history of abuse, neglect, or exploitation or a criminal history that would disqualify them from working with residents. The findings are: A. Record review of the Administrator's and DCS #s 1-3's staff files revealed that the EAR and CCHSP applications had not been submitted for any of these employees under the new facility ownership occurring on 01/01/19.	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 7 B. On 12/20/19 at 12:30 pm, during an interview with the Administrator, she confirmed that the EARs and CCHSP applications were not submitted for clearance for any staff members when there was a change in ownership on 01/01/19.	A 016		
A 019	7 NMAC 8.2.19 Staffing Ratios STAFFING RATIOS: The following staffing levels are the minimum requirements. A. The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents ' needs. (1) During resident waking hours, facilities shall have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents. (2) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty, awake and responsible for the care and supervision of the residents. (3) During resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises. (4) During resident sleeping hours, facilities with thirty-one (31) to sixty (60) residents shall have at least two (2) direct care staff persons on duty and awake at all times and at least one (1) additional staff person immediately available on the premises. (5) During resident sleeping hours, facilities with more than sixty-one (61) residents shall have at least three (3) direct care staff persons on duty and awake at all times and one (1) additional staff	A 019		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(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 019	Continued From page 8 person immediately available on the premises for each additional thirty (30) residents or fraction thereof in the facility. B. Upon request of the department, the facility shall provide the staffing ratios per each twenty-four (24) hour day for the past thirty (30) days. [7.8.2.19 NMAC - Rp, 7.8.2.18 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.19 A (2) Based on record review and interview, the facility failed to ensure that the night shift Direct Care Staff (DCS) were awake and available to provide care/supervision at all times. This deficient practice could likely have a negative effect the safety and welfare of all 4 (R #s 1-4) residents identified on the resident census provided by the Care Director (CD) on 12/19/19, to be at risk or harm if the DCS are not awake and available on the night shift to provide: 1. Care and services. 2. Medical attention. 3. Assistance in case of fire or other emergency requiring evacuation. The findings are: A. Record review of the facility's staff work schedule for December 2019, revealed that only one DCS is scheduled at the facility during the overnight (graveyard) shift. B. On 12/20/19 at 11:25 am, during an interview with the Administrator, she confirmed that: 1. Only one DCS is scheduled during the overnight shift and there are no other staff	A 019		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(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 019	Continued From page 9 members onsite and available during the overnight shift. 2. The DCS are allowed to sleep during the overnight shift. 3. The facility requested a waiver from the licensing authority to allow DCS to sleep during the overnight shift, which was denied.	A 019		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident's surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC;	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(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 020	Continued From page 10 (11) the facility's bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident's health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as "specialized" must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(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 020	Continued From page 11 continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident's surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in	A 020			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 12 writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010]	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(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 020	Continued From page 13 This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) Refer to Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings. B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude	A 020			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 14 renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them. C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health." SECTION 2. EMERGENCY. --It is necessary for the public peace, health and safety that this act take effect immediately. Based on record review and interview, the facility failed to ensure for 4 (R #s 1-4) of 4 (R #s 1-4) whose Admission/Discharge Agreements were reviewed for compliance included the required refund upon death information in NMAC 7.8.2.20 Regulations for Assisted Living Facilities and Senate Bill (SB) 0335 - 2013. This deficient practice has the potential for residents/resident's estate to be at risk of not receiving monies owed to them and/or being aware of extra charges that could occur for storage of the residents' belongings. The finding(s) are: A. Record review of R #s 1 & 4's Admission/Discharge Agreements revealed that there was no documentation of a refund provision in case of death in compliance with NMAC 7.8.2.20 and Senate Bill (SB) 0335 - 2013. B. On 12/20/19 at 12:30 pm, during an interview	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 15 with the Administrator, she confirmed that there was no documentation in R #s 1-4'S Admission/Discharge Agreements of a refund upon death in compliance with NMAC 7.8.2.20 and Senate Bill (SB) 0335 - 2013.	A 020		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 035	Continued From page 16 circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 035	Continued From page 17 product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged.	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(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 035	Continued From page 18 Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (5) Based on record review and interview the facility failed to ensure for 3 (R #s 1-3) of 4 (R #s 1-4) residents whose Medication Administration Records (MARs) were reviewed for compliance that they were included both the brand & generic names for all medications. These deficient practices have the potential for all residents to be	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 035	Continued From page 19 at risk of harm if medications do not have both the brand & generic names. The Direct Care Staff (DCS) who assist residents with medications do not recognize the name of the medication, which may result in medication errors occurring due to vital information missing on the MAR. The findings are: A. Record review of R #1's [REDACTED]/19 through [REDACTED]/19, MAR revealed that it did not include both the brand & generic names for: [REDACTED] B. Record review of R #2's [REDACTED]/19 through [REDACTED] 19, MAR revealed that it did not include both the brand & generic names for: [REDACTED] C. Record review of R #3's 12/01/19 through 12/18/19, MAR revealed that it did not include both the brand & generic names for Vitamin D3 Tablet (Arachitol/Calciol - Dietary supplement). D. On 12/20/19 at 12:30 pm, during an interview with the Administrator, she confirmed that the 12/01/19 through 12/18/19 MARs for R #s 1, 2 & 3 were missing either the brand or generic names of the medications listed above.	A 035		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2)	A 063		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(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 063	Continued From page 20 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 B. Reference NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition: 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. Based on observation and interview, the facility failed to ensure that the fire extinguishers were being inspected monthly as recommended by the manufacturer. This deficient practice has the potential for all residents, staff members and building occupants to be at risk of harm, injury, or death if a fire were to occur and the fire	A 063			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(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 063	Continued From page 21 extinguishers do not work. The findings are: A. On 12/19/19 at 8:20 am, during observation of the fire extinguishers in the facility revealed that the fire extinguishers in the hallway and kitchen had not been inspected monthly as recommended by the manufacturer. B. On 12/20/19 at 12:30 pm, during an interview with the Administrator, she confirmed that both fire extinguishers in the facility have not been inspected monthly as recommended by the manufacturer.	A 063		
A 064	7 NMAC 8.2.64 Fire Safety Equivalency System Rating FIRE SAFETY EQUIVALENCY SYSTEM RATING: In facilities without a sprinkler system; the fire safety equivalency system shall be conducted at least annually. The facility shall maintain an evacuation rating score of prompt when a fire safety equivalency system is required. [7.8.2.64 NMAC - Rp, 7.8.2.19 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.64 Based on record review and interview, the facility failed to have evidence of maintaining a score of prompt for the Fire Safety Equivalency System Rating (FSES). This deficient practice has the potential for all 4 (R #s 1-4) residents listed on the census provided by the Care Director, (CD) on 12/19/19, to be at risk of harm, illness and/or death, if staff cannot get the residents evacuated	A 064		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(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 064	Continued From page 22 in time if a fire were to occur in the building. The findings are: A. Record review of the facility's FSES scores for the facility for "2019" revealed a score of 1.6 resulting in a "slow" instead of "prompt" score as required for facilities that do not have a fire prevention sprinkler system. B. On 12/20/19 at 12:30 pm, during an interview with the Administrator, she confirmed that the facility's FSES score was "slow" and that she did not have enough DCS on duty and/or immediately available to maintain a FSES score of "prompt" as required for facilities without a fire prevention sprinkler system.	A 064		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC,	A 065		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 065	Continued From page 23 01/15/2010]	A 065		
	This REQUIREMENT is not met as evidenced by: 7.8.2.65 A Based on record review and interview, the facility failed to ensure that a fire drill was conducted and documented monthly on each 8-hour shift (morning, afternoon, graveyard) per quarter. This deficient practice has the potential for all 4 (R #s 1-4) residents listed on the census provided by the Care Director, (CD) on 12/19/19, to be at risk of harm, injury, or death if staff and residents are not aware of how to safely evacuate the building in case of a fire. The findings are: A. Record review of the facility fire drill documentation revealed no fire drills having been conducted during the overnight shift during any quarter in 2019. B. On 12/20/19 at 12:30 pm, during an interview with the Administrator, she confirmed that monthly fire drills were not conducted during the overnight shift during any quarter in 2019.			
A 069	7 NMAC 8.2.69 Memory Care Units	A 069		
	MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions: The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply.			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 069	Continued From page 24 (1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer ' s gets progressively worse and is fatal. (2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services. (3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain. (4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program. (5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit. B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process. (1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services. (2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside	A 069		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(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 069	Continued From page 25 health care provider. C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer's disease, or other pertinent information. D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident's primary care practitioner, in compliance with the requirements outlined in "Individual Service Plan," 7.8.2.26 NMAC, pursuant to a team meeting as described in "Exceptions to admission, readmission and retention," Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria: (1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident's needs; (2) medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. E. Assessments and reevaluations. (1) An assessment shall be completed by a registered nurse or a physician extender within	A 069		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(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 069	Continued From page 26 fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5) days after admission. (a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission. (b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit. (c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted. (2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident's stay in the assisted living facility memory care unit is still appropriate. F. Documentation in the resident's record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident's record: (1) the physician's diagnosis for admission to a secure environment or a memory care unit; (2) the pre-admission assessment; and (3) the re-evaluation(s).	A 069		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 069	Continued From page 27 G. Secured environment. (1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to: (a) double alarm systems; (b) gates connected to the fire alarm; and (c) tab alarms for residents at risk for elopement. (2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents. (a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident ' s legal representative,	A 069		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 069	Continued From page 28 if applicable and prior to the resident ' s admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for. (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.69 D E (1) (a-b) Based on record review, observation, and interview, the facility failed to ensure that: 1. An Individual Service Plan (ISP) was created in coordination with the resident's primary care practitioner (PCP), in compliance with the requirements outlined in "Individual Service Plan" 7.8.2.26 NMAC, pursuant to a team meeting as described in "Exceptions to admission, readmission and retention as described in Subsection C of 7.8.2.20 NMAC, identifying the resident's needs specific to the secured memory care unit and the services provided. 2. An assessment was completed by a registered nurse (RN) or a physician extender (PE) within fifteen (15) days prior to 01/01/19, by the new facility owner.	A 069		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(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 069	Continued From page 29 3. There were physician's orders stating the need for placement in a memory care unit by the new facility owner. This deficient practice has the potential for all 4 (R #s 1-4) residents listed on the census provided by the Care Director, (CD) on 12/19/19 to be at risk of harm if: 1. An assessment is not completed prior to admission by an RN or PE assessing the resident's needs specific to a secured memory care unit. 2. An ISP is not created in coordination with the resident's PCP identifying the resident's specific needs for care within a secured memory care unit. 3. Residents who do not require placement in a secured memory care unit are inappropriately admitted against their will or if their PCP has not determined the placement is needed for personal safety due to Alzheimer's and other related dementia behaviors. The findings are: A. Record review of R #s 1-4 resident files revealed no documentation that: 1. An ISP was created in coordination with their PCP(s). 2. An assessment by a registered nurse (RN) or physician extender (PE) occurred within 15 days prior to 01/01/19. 3. A physician provided a diagnosis or order for admission to a secured environment during or 15 days prior to 01/01/19. B. On 12/19/19 at 12:45 pm, during an observation of the front entrance, it was observed that a code was required to open the front door be entered into the security panel by a staff	A 069		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4099	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - DOGWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4014 ST ANDREWS SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 069	Continued From page 30 member to allow exiting the building. C. On 12/20/19 at 12:30 pm, during an interview with the Administrator, she confirmed that: 1. The facility's new owner took possession and began operations on 01/01/19. 2. The facility operates as a secured memory care unit requiring a code be entered to exit the facility that only staff members have access to . 3. There was no documentation that R #s 1-4 had an assessment by an RN within 15 days prior to 01/01/19. 4. R #1-4 files did not contain a pre-admission physician's orders stating the need for residents to be placed in a memory care (secured) unit after 01/01/19.	A 069		