STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2247	A. BUILDING: _____ B. WING _____	R-C 12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	906 PISTACHIO TRAIL ARTESIA, NM 88210

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{A 000}	Initial Comments	{A 000}		

The following deficiencies were cited during an offsite Revisit/Follow-up survey completed on 12/06/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living for Adults:

DEFINITIONS:
ADL: Activities of Daily Living
AREDS: Age Related Eye Disease Study
Assist: Assistance (short for)
CCHSP: Caregiver Criminal History Screening Program
DCS: Direct Care Staff
DNR: Do Not Resuscitate order
DOH: Date of Hire
EAR: Employee Abuse Registry
EMT: Emergency Medical Technician
EMS: Emergency Medical Services
ER: Extended Release
FDCS: Former Direct Care Staff
g: gram
HTN: Hypertension
IR: Incident Report(s)
LA: Licensing Authority
LPN: Licensed Practical Nurse
MAR: Medication Administration Record
mcg: microgram(s)
mg: milligram(s)
n/v: Nausea or vomiting
PA: Physician's Assistant
PRN: Pro re nata (as needed)
PO: By mouth
POA: Power of Attorney
R: Resident
RN: Registered Nurse
Q6: Every 6 hours
Q12: Every 12 hours

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{A 016}	Continued From page 1	{A 016}		
{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 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	{A 016}		

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{A 016}	Continued From page 2 (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: This is an uncorrected deficiency for survey dated 11/18/20 7.8.2.16 B (3) (7)	{A 016}		

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{A 016}	Continued From page 3 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, including the name, address, date of birth, social	{A 016}		

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{A 016}	Continued From page 4 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}		

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{A 016}	Continued From page 5 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.	{A 016}		

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{A 016}	Continued From page 6 The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint 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	{A 016}		

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{A 016}	Continued From page 7 applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (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: 1. All DCS providing care and services had been cleared by the EAR prior-to-hire. 2. The application and fingerprints for the CCHSP were submitted within 20 days of the date of hire. This deficient practice has the potential to affect the safety and welfare of all 14 (R #s 1-14) residents on the census provided by the Administrator on 11/16/22, if being provided care by DCS who may have a previous history of abusing, neglecting, and/or exploiting residents. The findings are: A. Record review of DCS #2's (date of hire 09/23/22) employee file, revealed that: 1. The EAR was not completed/submitted until 11/17/22. 2. There was no documentation that the fingerprints were submitted to the CCHSP within 20 days of hire and clearance letters weren't	{A 016}		

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{A 016}	Continued From page 8 received until 11/18/22. B. Record review of DCS #4's (date of hire 01/15/22) employee file, revealed that: 1. The EAR was not completed/submitted until 02/11/22. 2. There was no documentation that fingerprints were submitted to the CCHSP within 20 days of hire or clearance letters received. C. Record review of DCS #5's (date of hire 11/08/21) employee file, revealed that: 1. The EAR was not completed/submitted until 11/18/21 2. There was no documentation that fingerprints were submitted to the CCHSP within 20 days of hire and clearance letter was was not received until 01/04/22. D. Record review of DCS #6's (date of hire 01/15/22) employee file, revealed that: 1. The EAR was not completed/submitted until 02/17/22. 2. The fingerprints were not submitted to the CCHSP until 03/08/22, and clearance letter was not received until 03/09/22. E. Record review of DCS #7's (date of hire 12/01/21) employee file, revealed that: 1. The EAR was not completed/submitted until 12/16/21. 2. There was no documentation that applications and fingerprints were submitted to the CCHSP within 20 days of hire or clearance letters received. F. Record review of DCS #8's (date of hire 09/30/22) employee file, revealed that: 1. There was no documentation that the EAR was completed/submitted.	{A 016}		

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{A 016}	Continued From page 9 2. There was no documentation that their applications and fingerprints were submitted to the CCHSP within 20 days of hire or clearance letters received. G. On 11/29/22 at 3:22 pm, during an interview with DCS #8, she stated that she was not fingerprinted or cleared with EAR prior to working, but it was her fault, not the facility's, because she worked in Arizona before, and she was cleared there and she failed to look into it until about 2-3 weeks ago. H. On 12/06/22 at 8:45 am, during an exit conference with the Administrator, she confirmed the findings For DCS #s 2, and 4-8, listed above.	{A 016}		
{A 017}	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and	{A 017}		

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{A 017}	Continued From page 10 (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 A B C (1-2) (3 a-e) (4-12) Based on record review and interview the facility failed to ensure that the DCS received all the required trainings and documentation of completion and was maintained onsite at the facility for ability to review. (1) Sixteen (16) hours of supervised training prior to providing unsupervised care for residents. (2) Twelve (12) hours of orientation and annual trainings. This deficient practice could likely result in harm or injury for the 14 (R #s 1-14) residents	{A 017}		

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{A 017}	Continued From page 11 identified on the census provided by the Administrator on 11/16/22, if the DCS providing care have not received all required training and do not know how to properly care for residents. The findings are: Findings for DCS #1 A. Record review of DCS #1's training file, revealed no documentation of receiving 12 hours of the required orientation and/or annual trainings in the following areas: 1. Fire safety and evacuation. 2. First aid. 3, Safe food handling practices (for persons involved in food preparation) that includes a certificate of training completion. 4. Confidentiality of records and resident information. 5. Infection control. 6. Resident rights. 7. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. 8. Smoking policy for staff, residents and visitors. 9. Methods to provide quality resident care. 10. Emergency procedures. Findings for DCS #2 B. Record review of DCS #2's training file, revealed no documentation of receiving the state approved medication assistance training, including the certificate of training completion for staff that assist with medication delivery. Findings for DCS #3 C. Record review of DCS #3's training file, revealed no documentation of receiving the state approved medication assistance training,	{A 017}		

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{A 017}	Continued From page 12 including the certificate of training completion for staff that assist with medication delivery until 10/31/22. D. Record review of DCS #3's training file, revealed no documentation of receiving the required orientation and/or annual trainings in the following areas: 1. Fire safety and evacuation. 2. First aid. 3. Safe food handling practices (for persons involved in food preparation) that includes a certificate of training completion. 4. Confidentiality of records and resident information. 5. Infection control. 6. Resident rights. 7. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. 8. Smoking policy for staff, residents and visitors. 9. Methods to provide quality resident care. 10. Emergency procedures. 11. Medication assistance, including the certificate of training for staff that assist with medication delivery; and 12. the proper way to implement a resident ISP for staff that assist with ISPs. Findings for DCS #4 E. Record review of DCS #4's training file, revealed no documentation of receiving the required orientation and/or annual trainings in the following areas: 1. First aid. 2. Safe food handling practices (for persons involved in food preparation) that includes a certificate of training completion. 3. Confidentiality of records and resident information.	{A 017}		

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{A 017}	Continued From page 13 4. Infection control. 5. Resident rights. 6. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. 7. Smoking policy for staff, residents and visitors. 8. Methods to provide quality resident care. 9. Emergency procedures. 10. Medication assistance, including the certificate of training for staff that assist with medication delivery; and 11. the proper way to implement a resident ISP for staff that assist with ISPs. F. On 12/06/02 at 1:50 pm, during an interview with DCS #4, she stated that: 1. The facility management gave DCS #4 a packet of information and that there is a binder located in the med tech room that the staff are told to review on their own time. 2. She has never once seen a resident's ISP. 3. Staff are not paid while they review training materials. 4. She did not shadow anyone for the first 16 hours and was unsupervised for the first 16 hours of employment. 5. She has worked in the kitchen. 6. She has not received training on the following: a) First aid b) Food safety c) Confidentiality of records and resident information. d) Infection control e) Resident rights f) Reporting requirements for abuse, neglect, or exploitation in accordance with 7.1.13 NMAC. g) Smoking policy for staff, residents, and visitors. h) Methods to provide quality resident care.	{A 017}		

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{A 017}	Continued From page 14 i) Emergency procedures j) Medication assistance, including the certificate of training for staff that assist with medicine delivery. k). Proper way to implement a resident ISP for staff that assist with ISP's. Findings for DCS #5 G. Record review of DCS #5's training file, revealed no documentation of receiving the required orientation and/or annual trainings in the following areas: 1. First aid. 2. Safe food handling practices (for persons involved in food preparation) that includes a certificate of training completion. 3. Confidentiality of records and resident information. 4. Infection control. 5. Resident rights. 6. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. 7. Smoking policy for staff, residents and visitors. 8. Methods to provide quality resident care. 9. Emergency procedures. 10. Medication assistance, including the certificate of training for staff that assist with medication delivery. 11. Proper way to implement a resident ISP for staff that assist with ISPs. Findings for DCS #6 H. Record Review of DCS #6's employment file revealed no documentation of receiving the required orientation and/or annual trainings in the following areas: 1. First aid. 2. Safe food handling practices (for persons involved in food preparation) that includes a	{A 017}		

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{A 017}	Continued From page 15 certificate of training completion. 3. Confidentiality of records and resident information. 4. Infection control. 5. Resident rights. 6. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. 7. Smoking policy for staff, residents and visitors. 8. Methods to provide quality resident care. 9. Emergency procedures. 10. Medication assistance, including the certificate of training for staff that assist with medication delivery. 11. Proper way to implement a resident ISP for staff that assist with ISPs. I. On 11/29/22 at 10:01 am, during an interview with DCS #6, she stated that: 1. She assists residents with medications, but she has never taken the training for medication assistance, including the certificate of training for staff that assist with medication delivery. 2. She confirmed that she had no training other than her 16 hours of shadowing on her first two days of work and this consisted of mainly changing residents. Findings for DCS #7 J. Record review of DCS #7's employment file revealed a 10/20/22 certificate of training for staff that assist with medication delivery (received 323 days after hire date). K. Record review of DCS #7's employment file showed no documentation of receiving the required orientation and/or annual trainings in the following areas: 1. First aid.	{A 017}		

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{A 017}	Continued From page 16 2. Safe food handling practices (for persons involved in food preparation) that includes a certificate of training completion. 3. Confidentiality of records and resident information. 4. Infection control. 5. Resident rights. 6. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. 7. Smoking policy for staff, residents and visitors. 8. Methods to provide quality resident care. 9. Emergency procedures. 11. Proper way to implement a resident ISP for staff that assist with ISPs. L. On 11/29/22 at 10:57 am, during an interview with DCS #7, she stated that: 1. She did not have any onboard/orientation training because she has 10 years' experience in the field, but that the Assistant Manager completed a log showing that she had been trained during the month, sometime in December, 2021. 2. She never shadowed anyone for the required 16-hours of supervised training. 3. The Assistant Manager provided her with a med tech pamphlet to study and she took the test 3 - 6 months after working there. 4. She stated that she began passing medications on her first day of work. 5. She confirmed that she took the required state-approved training and received her certificate of training for staff that assist with medication delivery a few weeks ago (10/20/22). 6. She stated that she had not completed any of the annual trainings and she was unaware that annual trainings were required. Findings for DCS #8	{A 017}		

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{A 017}	Continued From page 17 M. Record review of DCS #8's employment file revealed an 11/21/22 certificate of training for staff that assist with medication delivery (received 52 days after hire date). N. Record review of DCS #8's employment file showed no documentation of receiving the required orientation and/or annual trainings in the following areas: 1. First aid. 2. Safe food handling practices (for persons involved in food preparation) that includes a certificate of training completion. 3. Confidentiality of records and resident information. 4. Infection control. 5. Resident rights. 6. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. 7. Smoking policy for staff, residents and visitors. 8. Methods to provide quality resident care. 9. Emergency procedures. 10. Proper way to implement a resident ISP for staff that assist with ISPs. M. On 11/18/22 at 10:55 am, during a facetime interview and tour with the Assistant Manager, she stated: 1. There are 11 memory care residents, but there is not a separate memory care unit within the facility. 2. All DCS are responsible for all residents, including memory care residents. 3. All DCS are also med techs and they assist with passing medications and updated the MAR 4. All DCS are trained in Memory/Alzheimer's care. 5. All DCS are trained in a state-approved medication assistance training program, and they	{A 017}		

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{A 017}	Continued From page 18 have received certificates of Medication assistance. N. On 12/06/22 at 8:45 am, during an exit conference with the Administrator, she confirmed the training findings listed above for DCS #'s 1 -8.	{A 017}		
{A 024}	7 NMAC 8.2.24 Assistance with Daily Living ASSISTANCE WITH DAILY LIVING: The facility shall supervise and assist the residents, as necessary, with health, hygiene and grooming needs, to include but not limited to the following: A. eating; B. dressing; C. oral hygiene; D. bathing; E. grooming; F. mobility; and G. toileting. [7.8.2.24 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: This is an uncorrected deficiency from survey dated 11/18/20 7.8.2.24 D F G Based on record review and interview, the facility failed to ensure that a 2-person assistance was provided for 1 (R #3) of 1 (R#3) resident, pursuant to her ISP dated 11/02/22. This deficient practice could result in harm or injury to R #3. The findings are: A. Record review of R #3's Evaluation and	{A 024}		

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{A 024}	Continued From page 19 Assessment dated 11/03/22, revealed the resident requires assistance with the following ADL's as follows: 1. Extensive assistance for ability to transfer 2. 2-person assistance for showers 3. 2-person assistance for wheelchair usage 4. 2-person assistance for ambulation 5. 2-person assistance for bowel incontinence 6. 2-person assistance for bladder incontinence B. Record review of R #3's ISP dated 11/03/22, revealed that the resident requires assistance with the following ADLs as follows: 1. 2-person assistance with ambulation 2. 2-person assistance using the wheelchair 3. Assistance with showering and hygiene 4. Assistance with dressing 5. Assistance with bladder incontinence 6. Assistance with bowel incontinence 7. All meals are fed to resident C. On 11/15/22 at 10:55 am, during an interview with the Assistant Manager, she stated that there are no residents at the facility who require a 2-person assist. D. On 12/06/22 at 8:45 am, during an exit conference, both the Assistant Manager and the Administrator stated that R #3 only requires a 1-person assist. E. On 12/12/22 at 11:57 am, during an interview with the facility's LPN, she stated that: 1. She convened with R #3's family and the Administrator at the beginning of October 2022, and they determined that R #3's ISP would be updated to reflect a change from a 1-person assist to a 2-person assist. 2. Near the end of October 2022, the LPN met with the Administrator, Assistant Manager, and	{A 024}		

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{A 024}	Continued From page 20 staff, and she informed them all of the following changes to R #3's care plan as follows: a) R #3's ADL status changed from a 1-person assist to a 2-person assist, effective immediately. b) That R #3's ISP would be updated to reflect current changes by the end of October 2022. 4. On 11/02/22, the LPN updated R #3's ISP to reflect the 2-person assist change, and after signing it, she forwarded the updated ISP to the Administrator for approval. 5. On 11/03/22, the Administrator signed the ISP, and returned a signed copy back to the LPN.	{A 024}		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident;	A 032		

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A 032	Continued From page 21 (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: REPORTING OF INCIDENTS 7.8.2.32 A. (1) - (2), B. (1) - (3) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W, 8 B. (2), 10 C. W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including 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, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation,	A 032		

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injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form.

C. All licensed health care facilities shall conduct a complete investigation and report the actions taken and conclusions reached by the facility within five (5) days of discovery of the incident. [7.1.13.10 NMAC - Rp, 7.1.13.11 NMAC, 7/1/14]

Based on record review and interview, the facility failed to ensure for 1 (R #8) of 5 (R #s 1, & 6-9) residents whose IRs were reviewed for compliance for any possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury were:

1. Reported to the Licensing Authority within 24 hours or the next business day if it is a weekend or a holiday.
2. The facility conducted and documented the investigation of all reportable incidents within five (5) business days and submit a copy of the investigation report to the licensing authority.

These deficient practices could potentially result in the 14 (R #s 1-14) residents listed on the census provided by the facility's Resident Care Coordinator on 11/16/22, to be at risk of harm, injury, and/or death, due to the facility failing to report any "Reportable incident" to the Licensing

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Authority for oversight and complete an investigation to include a narrative description of the incident, the result of the facility's investigation, and plans for further actions in response to the incident.

The findings for R #8 are:

A. Record review of the facility's IRs for R #8 revealed:
1. According to the facility's Internal IR dated 05/15/22, R #8:
a) Had an unwitnessed fall, and [redacted] was found on [redacted] on a toilet paper roll and walker at [redacted] by the door.
b) A DCS asked R #8 what happened, and [redacted] response was, "It happened so fast, I don't know."
c) The Assistant Manager told the DCS to notify the nurse, FDCS #10.
d) FDCS #10 texted DCS #7 with directives on dressing wounds.
e) The resident was bandaged by staff and vitals were taken
f) R #8's POA was notified by voicemail message.
g) A follow-up notation at the bottom of the 05/15/22 internal IR was signed and dated by the Administrator on 05/15/22 and it stated: "Right arm, bandage changed, cleaned, healing well."

B. On 12/06/22 at 8:45 am, during an exit conference, the Administrator stated that:
1. She recalled the incident involving R #8 on 05/15/22.
2. She went to the facility to check on R #8 and she found that [redacted] only sustained a [redacted] but she wasn't certain if it was the [redacted]
3. There was no blood anywhere and that [redacted] only needed a small Band-Aid on [redacted]

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A 032	Continued From page 24 4. The POA was notified, and that [redacted] came to the facility and [redacted] said not to take [redacted] to the hospital. 5. The incident was not reported to the Licensing Authority (LA) and there was not 5-day follow up or investigative report submitted because the Administrator felt it was a minor incident. C. On 12/09/22 at 10:23 am, during an interview with R #8's PA [redacted] stated the following: 1. [redacted] was R #8's healthcare provider. 2. The following medications, listed on R #8's MAR, are blood thinners, and could cause bleeding, as follows: a [redacted] 3. [redacted] stated that R #8 should have received medical attention from a licensed medical provider if [redacted] injuries caused excessive bleeding. 4. She stated that even with a DNR in place, the appropriate response for excessive bleeding due to blood thinners, would be for a licensed medical professional to: a) Provide care to stop the bleeding b) Clean and dress the wound for infection control c) Make a medical determination on whether additional medical assistance was required. D. On 01/15/22 at 1:50 pm, during an interview with DCS# 4, she stated the following regarding a 05/15/22 unwitnessed fall incident involving R #8: 1. She found R #8 on [redacted] back in the bathroom.	A 032		

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A 032	Continued From page 25 2. That there was so much blood, that it looked like a murder scene. 3. She didn't know what to do, so she called the Administrator, the nurse, and the assistant manager for advice. 4. That the nurse (FDCS #10) did not call her back until the next day afternoon. 5. That the Administrator never called her back 6. That the only person who called her back was the Assistant Manager and after calming her down, she told her to do the following: a) Detail and describe all of the injuries. b) Take photographs of the scene and [redacted] injuries and to forward them to her, the nurse and the Administrator. c) The Assistant Manager walked her through cleaning, dressing, and bandaging all of [redacted] wounds using different bandages, including [redacted] 7. DCS #4 stated the following to the Assistant manager: a) That he was bleeding excessively and there was blood everywhere. b) That [redacted] was on blood thinners and this might be why [redacted] was bleeding so much. c) That [redacted] had injuries all over [redacted] and she described exactly where they were. 8. When asked if she was involved in completing the internal IR, she said that there were two DCS there that night, and the other one (DCS #7) completed the internal IR. 9. When asked if she or DCS #7 had submitted an incident report to the Licensing Authority, she said no, that she had never been trained on that. 10. When asked what happened to the photographs, she stated that she sent them to the Administrator, the Assistant Manager, and the Nurse.	A 032		

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A 032	Continued From page 26 E. On 12/09/22 at 9:05 am, during an interview with R #8's POA, [redacted] stated that: 1. The facility always called him when there were incidents, but he could not recall the 05/15/22 incident. 2. When asked if he remembered the Assistant Manager or the Administrator calling him to notify him of the unwitnessed fall on 05/15/22, he said that happened all the time, but he couldn't remember the 05/15/22 incident. 3. When asked if he recalled giving directives on the care of [redacted] after coming into the facility and making an assessment, he said that happened many times, but he couldn't recall this particular incident. 4. He stated that he had a home 70 miles away and usually when they called about something, he takes the drive over. F. On 12/13/22 at 11:02 am, during a follow-up interview with DCS #4, she stated that: 1. The incident report is erroneous as follows: a) It states that the nurse gave directives on dressing R #8's wounds, but it was actually the Assistant Manager that gave the directives. b) The POA was not notified of the incident; he was on a trip in Arizona, but [redacted] (R #8's [redacted] was called and no answer so a message was left. 2. When asked was came into the facility to assist at the time of the incident, she stated that nobody came in to help. 3. When asked if the POA or [redacted] came into the facility the night of the incident with directives on R #8's care, she said that did not happen. 4. Three days after the incident, when she returned to work, she noticed that R #8's bandages still had not been changed. 5. When asked how she knew that R #8's	A 032		

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	2247	A. BUILDING: _____ B. WING _____	R-C 12/06/2022

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A 032	Continued From page 27 bandages hadn't been changed, she said that she had initialed her bandages and all of the bandages still had her initials on them. G. On 12/14/22 at 3:04 pm, during an interview with the Administrator, she confirmed that the incident on 05/15/22 was not reported to the Licensing Authority that and no 5-day follow up or investigative report was submitted. The Administrator stated that: 1. There was hardly any blood at the scene. 2. When asked if she was at the scene, she confirmed that she was not. 3. There were photographs taken of the 05/15/22 incident involving R #8. 4. She stated that she would share all photographs with me. H. On 12/14/22 at 5:08 pm, the Administrator emailed one photograph of R #8's back taken on 05/15/22, after [redacted] was cleaned up. The photograph reveals 4 large wounds with skin peeled back on [redacted]	A 032		
{A 069}	7 NMAC 8.2.69 Memory Care Units 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. (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	{A 069}		

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{A 069}	Continued From page 28 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 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	{A 069}		

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{A 069}	Continued From page 29 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 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 069}		

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{A 069}	Continued From page 30 (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). 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	{A 069}		

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{A 069}	Continued From page 31 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, 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	{A 069}		

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{A 069}	Continued From page 32 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: This is an uncorrected deficiency from 11/18/20 survey. 7.8.2.69 C Based on record review and interview the facility failed to ensure that the Direct Care Staff (DCS) received twelve (12) hours of Memory Care/Dementia/Alzheimer's training annually. This deficient practice could likely result in the 14 (R #s 1-14) residents to be at risk of not receiving the individual (physical, mental, social) care and services needed if the DCS have not completed the required 12 hours of annual specialized Dementia/Alzheimer's training. The findings are: A. Record review of DCS #3 (hire date 03/16/16) revealed, no documentation that she received/completed the required annual twelve (12) hours of Dementia/Alzheimer's training.	{A 069}		

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{A 069}	Continued From page 33 B. Record review of DCS #5 (hire date 11/08/21) revealed no evidence of the required 12 hours of annual twelve (12) hours of Dementia/Alzheimer's training. C. On 12/06/22 at 8:45 am, during an exit conference with the Administrator, she confirmed that DCS # 3 and #5 did not receive the required annual twelve (12) hours of Dementia/Alzheimer's training.	{A 069}		