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	2285	A. BUILDING: _____ B. WING _____	C 08/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	601 W CHERRY LANE CARLSBAD, NM 88220

(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 000	Initial Comments The following deficiencies were cited as a result of a Full-Onsite/Complaint survey completed on 08/06/17 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake NM#30335 was substantiated with deficiencies cited.	A 000		
A 008	7 NMAC 8.2.8 General Licensing Requirements GENERAL LICENSING REQUIREMENTS: A. Licensure is required. No person or entity shall establish, maintain or operate an assisted living facility without first obtaining a license. B. Application for licensure. An initial or renewal application shall be made on the forms prescribed by and available from the licensing authority. The issuance of an application form is not a guarantee that the completed application will be accepted, or that the department will issue a license. Information provided by the facility and used by the licensing authority for the licensing process shall be accurate and truthful. The licensing authority will not issue a new license if the applicant has had a health facility license revoked or renewal denied or has surrendered a license under threat of revocation or denial of renewal. The licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of applicable rules found to be class A or class B deficiencies as defined in Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC or has been non-compliant with plans of correction. The licensing authority will not issue a license until the applicant has supplied all of the information that is required by this rule. Any facility that fails to participate in good faith by falsifying information presented in the licensing process shall be	A 008		

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A 008	Continued From page 1 denied licensure by the department. The following information shall be submitted to the licensing authority for approval: (1) a letter of intent that includes the proposed physical address, the primary population of the facility and a summary of the proposed services; after the letter of intent has been received, an application packet including; the application form, fee schedule and the licensing rule will be issued to the applicant by the licensing authority; (2) the completed and notarized application and the appropriate non-refundable fee(s); (3) a program narrative identifying and detailing the geographic service area, the primary population including any special needs requirements, along with a full description of the services that the applicant proposes to provide including: (a) a description of the characteristics of the proposed population of the facility; (b) a description of the services and care that will be provided to the residents; (c) a description of the anticipated professional services to be offered to the residents; and (d) a description of the facility ' s relationship to other services and related programs in the service area and how the applicant will collaborate with them to achieve a system of care for the residents. (4) policies and procedures annotated to this rule; (5) evidence to establish that the applicant has sufficient financial assets to permit operation of the facility for a period of six (6) months; the evidence shall include a credit report from one of the three recognized credit bureaus with a minimum credit score of six-hundred fifty (650) or above; (6) copies of organizational documents to include the following list of items:	A 008		

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A 008	Continued From page 2 (a) the names of all persons or business entities that have at least five percent (5%) ownership interest in the facility, whether direct or indirect and whether in profits, land or building; this includes the owners of any business entity which owns all or part of the land or building; (b) the identities of all creditors that hold a security interest in the premises, whether land or building; (c) any changes in ownership or management shall be reported to the department within thirty (30) days; (7) building plans as required at 7.8.2.41 NMAC of this rule; (8) fire authority approval as required at 7.8.2.60 NMAC of this rule; (9) a letter of approval or exemption from the local health authority having jurisdiction for the food service and the kitchen facility; (10) a copy of liquid waste disposal and treatment system permit from local health authority having jurisdiction; (11) approval from local zoning authority; (12) building approval (certificate of occupancy); and (13) any other information that the applicant wishes to provide or that the licensing authority may request. C. Application for amended license. A licensee shall submit an application for an amended license and the required non-refundable fee to the licensing authority prior to a change with the facility. An amended license is required for a change of: location, administrator, facility name, capacity or any modification or addition to the building. (1) An application for a change of the facility administrator or change of the administrator ' s name shall be submitted to the licensing authority	A 008		

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A 008	Continued From page 3	A 008		

within ten (10) business days of the change.
(2) An application for increase in capacity shall be accompanied by a building plan pursuant to 7.8.2.41 NMAC of this rule. A facility shall not increase census until the licensing authority has reviewed and approved the increase and has issued a new license that reflects the approved increase in capacity.
D. Application for license renewal. Each facility shall apply for a renewal of the annual license within thirty (30) business days prior to the license expiration date by submitting the following items:
(1) an application and the required fee;
(2) an updated program narrative, if the facility has changed the program or the focus of services;
(3) the annual fire inspection report; and
(4) the licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of this rule or has been noncompliant with plans of correction or payment of civil monetary penalties.
E. License. Any person or entity that establishes, maintains or operates an assisted living facility shall obtain a license as required in this rule before accepting residents for care or providing services.
(1) Each facility that provides care or treatment shall obtain a separate license. The license is non-transferable and is only valid for the facility to which it is originally issued and for the owner or operator to whom it is issued. It shall not be sold, reassigned or transferred.
(2) The maximum capacity specified on the license shall not be exceeded.
(3) If the facility is closed and the residents are removed from the facility, the license shall be returned to the licensing authority. Written notification shall be issued to all residents or the

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A 008	Continued From page 4 residents ' surrogate decision maker and the licensing authority at least thirty (30) calendar days prior to the closure. F. Temporary license. (1) A temporary license may be issued to a new facility before residents are admitted provided that the facility has met all of the life safety code requirements as stated in this rule and policies and procedures for the facility have been reviewed and approved. (2) Upon receipt of a temporary license, the facility may begin to admit up to three (3) residents. (3) After the facility has admitted up to three (3) residents, the facility operator or owner shall request an initial health survey from the licensing authority. (4) Following a determination of compliance with this rule by the licensing authority, an annual license will be issued. The renewal date of the annual license is based on the initial date of the first temporary license. (5) The licensing authority has the right to determine compliance or noncompliance. (6) A temporary license shall cover a period of time, not to exceed one hundred twenty (120) calendar days. (7) No more than two (2) consecutive temporary licenses shall be issued. If a second temporary license is issued, an additional non-refundable fee is required. If all requirements are not met within the two hundred forty (240) day time frame, the applicant shall repeat the application process. G. Annual license. An annual license is issued for one (1) year for a facility that has met all the requirements of this rule. H. Display of license. The facility shall display the license in a conspicuous public place that is visible to residents, staff and visitors.	A 008		

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A 008	Continued From page 5 I. Unlicensed facilities. Any person or entity that opens or maintains an assisted living facility without a license is subject to the imposition of civil monetary penalties by the licensing authority. Failure to comply with the licensure requirements of this rule within ten (10) days of notice by the licensing authority may result in the following penalties pursuant to Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC. (1) A civil monetary penalty not to exceed five-thousand dollars ($5,000) per day. (2) A base civil monetary penalty, plus a per-day civil monetary penalty, plus the doubling of penalties as applicable, that continues until the facility is in compliance with the licensing requirements in this rule. (3) A cease and desist order to discontinue operation of a facility that is operating without a license. (4) Additional criminal penalties may apply and shall be imposed as necessary. [7.8.2.8 NMAC - Rp, 7.8.2.8 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.8 H Based on observation and interview, the facility failed to ensure that the facility's Assisted Living License was posted in a conspicuous place. If the facility license is not displayed in a conspicuous place, then the 12 (R #s 1-12) residents listed on the resident census provided by the House Manager (HM) on 08/04/17, visitors, and staff will not know if the facility has and/or is maintaining a current license as an Assisted Living Facility. The findings are:	A 008		

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A 008	Continued From page 6 A. On 08/06/17 at 10:52 am, during observation, the facility's Assisted Living License was observed to be posted in the administrator's office and not where it could be viewed by residents, visitors, and staff. B. On 08/06/17 at 10:53 am, during interview with the Administrator, he confirmed that the facility's Assisted Living License was not posted where it could be viewed by residents, visitors, and staff.	A 008		
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 (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights;	A 017		

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A 017	Continued From page 7 (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 C (2) (3) (a) (b) (c) (d) (e) (9) (10) (11) (12) Based on record review and interview the facility failed to ensure that 3 (DCS #s 1, 3 and 4) of 4 (DCS #s 1-4) Direct Care Staff had completed: 1. 12-hours of Orientation and Annual training. 2. 16-hours of Supervision. This deficient practice has the potential for all 12 (R #s 1-12) residents on the census provided by the House Manager on 08/04/17, to be at risk of harm or injury if staff have not received training on the proper methods of providing care and services. The findings are: A. Record review of DCS #1's training file revealed,	A 017		

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A 017	Continued From page 8 1. Orientation and Training document dated: Year 2017, for "Staff Orientation and Training for Assisted Living" signed by DCS #1 and dated 07/10/17, did not include each of the one hour training's listed below: a. First Aid. b. Safe food handling practices: (i) instructions in proper storage (ii) preparation and serving of food (iii) safety in food handling (iv) appropriate personal hygiene (v) infectious and communicable disease control c. Methods to provide quality resident care. d. Emergency procedures. e. Medication Assistance. f. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist with ISPs. 2. Orientation and Training document dated: Year 2017, for "Staff Orientation and Training for Assisted Living" signed by DCS #1 and dated 07/10/17, did not state who was conducting the training's. 3. No documentation for the required 16-hours of supervised training prior to providing unsupervised care for residents. B. Record review of DCS #3's training file revealed, 1. Orientation and Training document dated: 07/10/17, for "Staff Orientation and Training for Assisted Living" signed by DCS #1 and dated 07/10/17, did not include each of the one hour training's listed below: a. First Aid b. Safe food handling practices: (i) instructions in proper storage (ii) preparation and serving of food	A 017		

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A 017	Continued From page 9 (iii) safety in food handling (iv) appropriate personal hygiene (v) infectious and communicable disease control c. Methods to provide quality resident care. d. Emergency procedures. e. Medication Assistance. f. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist with ISPs. 2. Orientation and Training document dated: Year 2017, for "Staff Orientation and Training for Assisted Living" signed by DCS #1 and dated 07/10/17, did not state who conducted the training's. 3. No documentation for 16-hours of the required supervised training prior to providing unsupervised care for residents. C. Record review of DCS #4's training file revealed, 1. Orientation and Training document (for annual training) dated: Year 2017, for "Staff Orientation and Training for Assisted Living" and Annual Meeting Agenda 2017 document dated 06/27/17, did not include: a. First Aid. b. Safe food handling practices: (i) instructions in proper storage (ii) preparation and serving of food (iii) safety in food handling (iv) appropriate personal hygiene (v) infectious and communicable disease control c. Emergency procedures. d. Medication Assistance. e. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist with ISPs.	A 017		

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A 017	Continued From page 10 2. Orientation and Training document (for annual training) dated: Year 2017, for "Staff Orientation and Training for Assisted Living," did not state who conducted the trainings. D. On 08/06/17 at 10:45 am, during interview with the Administrator, he confirmed that the training document for DCS #s 1, 3 & 4 were only check lists and are missing the above listed state required trainings.	A 017		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be	A 026		

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A 026	Continued From page 11 provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (1) (2) Based on record review and interview the facility failed to ensure for 1 (R #1) of 1 (R #1) resident who died after falling off [redacted] bed and getting [redacted] head (covered with blankets) caught in a bedrail that was in the wrong position (head of the bed), that [redacted] Individual Service Plan (ISP) had been updated to include the use, need for, and required positioning (mid-mattress) of bedrail. If information regarding the use, need for, and required positioning (mid-mattress) of the bedrail was not included in the ISP then Direct Care Staff and other medical professionals would not be aware and possibly able to prevent R #1's death. The findings are: A. Record Review of R #1's ISP, dated 07/24/17, revealed no documentation of [redacted] need for or that a bedrail was being used.	A 026		

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A 026	Continued From page 12 B. On 08/08/17 at 9:32 am, during interview with the Administrator, he confirmed that R #1's ISP did not include documentation that a bedrail was used.	A 026		
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; (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,	A 032		

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A 032	Continued From page 13 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32. B (2) (3) Based on record review and interview, the facility failed to ensure for 3 (R #s 1-3) of 3 (R #s 1-3) residents who had falls with injuries that: 1. An internal investigation was conducted of how and/or why the incident/injuries occurred. 2. An action plan with acceptable preventative measures was included in the the facility's 5-day follow-up investigation report to the Licensing Authority. This deficient practice has the potential for all 12 (R #s 1-12) residents identified on the census list provided by the House Manager on 08/04/17 to be at risk of harm, injury, or death if the facility does not: 1. Conduct internal investigations as to why and/or how incidents of possible abuse, neglect, exploitation, or unusual occurrences occurred. 2. Develop an action plan with acceptable preventative measures to prevent future incidents of death, injury, or harm of residents and include the results in the facility's 5-day follow-up investigation report to the Licensing Authority to ensure facility oversite. The findings are: A. Record review of the facility Incident Self-Report dated 07/29/17 for R #1, revealed that on 07/29/17 at 7:00 am, while doing rounds, Direct Care Staff (DCS #s 1 and 2) discovered R #1 with [redacted] head stuck between the bed rail and mattress with [redacted] body on the floor, wrapped in	A 032		

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A 032	Continued From page 14 [redacted] blankets. The report stated that the DCS (unnamed) picked R #1 up over the rail and onto the floor. They then removed the blanket from [redacted] head, [redacted] face and lips were purple. DCS (unnamed) checked for a pulse and called 911, dispatch then instructed DCS (unnamed) to start CPR. The report stated that the only facility preventative action plan to be implemented was that the Administrator would put a "no bed rail" policy in place unless doctor's orders are given. B. Record review of the facility Complaint Narrative Investigation Report dated 07/31/17 for R#1, revealed no documentation that the facility conducted an investigation as to how/why the incident of R #1's death occurred and what preventative measures were put in place to prevent a similar incident from happening again. C. On 08/04/17 at 3:58 pm, during observation, R #2 was observed to have a [redacted] R #2 was unable to be interviewed due to [redacted] D. Record review of the facility Incident Self-Report dated for 07/26/17 for R #2, revealed that on 07/26/17 [redacted] was coming in from the outside and had a fall with injuries. E. Record review of the facility Complaint Narrative Investigation Report dated 07/28/17 for R #2, revealed that [redacted] had a [redacted] R #2 was assessed by the facility RN (Registered Nurse) and transported to the hospital by ambulance. There is no documentation that the facility conducted an internal investigation as to how/why her injuries occurred (tripping hazards, proper shoes, etc.).	A 032		

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A 032	Continued From page 15 F. Record review of the facility Incident Self-Report dated 07/30/17 for R #3, revealed that on 07/30/17 resident called for assistance and was found on the floor with cuts, skin tears, and blood. R #3 stated he dropped [redacted] cane and bent over to get it. G. Record review of the facility Complaint Narrative Investigation Report dated 07/31/17, revealed no documentation that the facility conducted an internal investigation to determine how/why R #3 sustained [redacted] injuries during the fall. H. On 08/04/17 at 4:18 pm, during interview with R #3, [redacted] stated that [redacted] fell on [redacted] first night at the facility 07/29/17 (Incident Reports states fall occurred on 7/30/17), [redacted] I. On 08/04/17 at 4:18 pm, during observation of R #3's room, the desk was observed to have a pull-out table that blocks part of the pathway between the desk and the bed. J. On 08/06/17 at 10:30 am, during interview with the Administrator and House Manager, they confirmed that the facility did not conduct an internal investigation as to how/why the incident of R #1's death occurred and that acceptable preventative measures were included in the 5-day follow-up report to the Licensing Authority. They also confirmed that the facility did not conduct internal investigations as to how/why R #2's and R #3's injuries occurred.	A 032		
A 033	7 NMAC 8.2.33 Resident Rights	A 033		

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A 033	Continued From page 16 RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes;	A 033		

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A 033	Continued From page 17 (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility;	A 033		

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A 033	Continued From page 18 (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (4) (10) (11) (a)	A 033		

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A 033	Continued From page 19 Based on record review, observation, and interview the facility failed to ensure for 1 resident (R #1) of 1 (R #1) resident who died was free from neglect and was provided a safe restraint free environment due to: 1. Allowing the use of a physical restraint (bed rail) without a physician's order, that was incorrectly placed next to the resident's head. 2. The Direct Care Staff (DCS) not: a. Following the Individual Service Plan (ISP), to visually check on the resident every 2 hours (q2hrs). b. Passing on change of condition information at shift change, c. Reviewing resident information in the computer at the beginning of each shift. d. Receiving training on how and what resident information to document into the computer. This deficient practice has the potential for the 12 (R #s 1-12) residents identified on the census list provided by the House Manager on 08/04/17, to be at risk of harm, injury, or death if: 1. Bed rails are used without a physician's order and incorrectly placed next to the resident's head. 2. The Direct Care Staff (DCS) are not: a. Following the Individual Service Plan (ISP), to visually check on the resident q Q2hrs. b. Not passing on change of condition information at shift change, c. Not reviewing resident information in the computer at the beginning of each shift. d. Receiving training on how and what resident information to document into the computer. Findings related to resident's death	A 033		

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A 033	Continued From page 20 A. Record review of the facility Incident Self-Report dated 07/29/17 for R#1, revealed that on 07/29/17 at 7:00 am, while doing rounds, Direct Care Staff (DCS #s 1 and 2) discovered R #1 with his head stuck between the bed rail and mattress with [redacted] body on the floor, wrapped in [redacted] blankets. The report stated that the DCS (unnamed) picked R #1 up over the rail and onto the floor. They then removed the blanket from [redacted] head, [redacted] face and lips were purple. DCS (unnamed) checked for a pulse and called 911, dispatch then instructed DCS (unnamed) to start CPR. The report stated that the only facility preventative action plan to be implemented was that the Administrator would put a "no bed rail" policy in place unless doctor's orders are given. B. Record review of the facility Complaint Narrative Investigation Report dated 07/31/17 for R#1, revealed no documentation that the facility conducted an investigation as to how/why the incident of R #1's death occurred and what preventative measures were put in place to prevent a similar incident from happening again. C. Record review of the police report dated 07/29/17 revealed that the officer was dispatched to the facility for an unattended death at approximately 7:20 am. The Officer made contact with DCS #2, who reported that at approximately 7:15 am, she went into R #1's room to check on [redacted] and found [redacted] to be deceased. [redacted] legs were off the bed, but body was still lying on the bed and [redacted] head was caught between the bar of the bed rail and the bed when she found [redacted] R#1 was then removed from the bed and placed on the ground, 911 was called. D. On 08/04/17 at 3:50 pm, during interview with	A 033		

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A 033	Continued From page 21 DCS #s 1 and 2, they stated that approximately 3 months ago R #1 rolled out of bed and the family choose to used the bedrail and installed it at the head of the bed instead of mid-mattress. [redacted] family hoped the bed rail would let [redacted] know [redacted] was near the edge of the bed and [redacted] would roll back over. E. On 08/04/17 at 4:00 pm, during observation and interview with the House Manager (HM) of R #1's bed, the bed rail was observed to be positioned at the end of the bed where [redacted] head would be when sleeping. The bed rail was observed to only have a top bar that ran parallel with with the bed and to two horizontal rails that attached to bars that went between the box spring and mattress. There was no middle bar that would prevent R #1's head from getting caught between the bedrail and mattress. The HM stated that she was told that when DCS #2 found R #1[redacted] head was between the bed rail and the mattress, and [redacted] body was on the floor with [redacted] sheets wrapped around [redacted] The HM confirmed that the bedrail did not have a middle bar to prevent R #1's head from getting caught between the bedrail and mattress. F. On 08/04/17 at 4:07 pm, during interview with the Administrator and HM, The Administrator stated that after R #1 fell out of bed and was injured that on 05/02/17 he met with R #1's family and recommended a scooped mattress or a mat on the floor instead of the rail. The family wanted the rail so R #1 could use it to reposition [redacted] (meeting documented at the end of the 05/01/17 Incident Report). The Administrator and HM confirmed that R #1 regularly rolled up in [redacted] blankets. They stated that R #1 did have a call-light pendant, was coherent, and had very [redacted] The HM reported that R #1 was	A 033		

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approximately 5 feet 9-10 inches tall and weighed [redacted]/17.

G. On 08/05/17 at 9:14 am, during interview with DCS #1 she stated that when she and DCS #2 went to check on R #1 at approximately 7:10 am on 07/29/17, they found [redacted] with [redacted] head in the bar of the bed rail and [redacted] body was hanging on the floor, and [redacted] looked deceased. DCS #2 called for assistance, then DCS #3 arrived and lowered R #1 to the floor and DCS #1 called 911, she gave the phone to DCS #3 and 911 suggested DCS #3 start CPR (cardiopulmonary resuscitation).

H. On 08/05/17 at 10:00 am, during interview with DCS #2, she stated that on 07/29/17 at 7:00 am, she was doing rounds with DCS #4 and decided to check on R #1 before leaving her shift. DCS #2 stated that she and DCS #1 went to check on R #1 together. DCS #2 stated that when she walked into R #1's room she saw [redacted] head stuck in the bed rail and [redacted] body hanging off the bed with the blankets holding [redacted] up. After she called for help, DCS #s 3 and 4 came in and helped lift R #1 off the bed rail and onto the floor. DCS #2 stated that she does not know if [redacted] was still breathing, but did not hear R #1 gasp when they put [redacted] on the floor.

I. On 08/05/17 at 11:00 am, during interview with DCS #3, she stated that she was in the dining room when she heard DCS #2 call for help, she thought R #1 had fallen again, but when DCS #2 called out again, she knew something was seriously wrong. When she entered R #1's room, she saw that someone (not sure who) had removed the blanket from around [redacted] face and saw that [redacted] had choked. [Name of Resident], a former firefighter helped her get R #1 on the floor

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and she began CPR compressions (R#1 did not have a DNR (do not resuscitate) order). 911 was called.

J. On 08/05/17 at 11:00 am, during interview with DCS #3 in R #1's room, she confirmed that the bed rail was at the end of the bed where R #1's head would be when [redacted] was asleep. DCS #3 stated that R #1's head (from jawbone up) was inside the bar of the bedrail and both [redacted] arms and legs were tangled up in the blankets, with [redacted] body hanging off the bed, and [redacted] feet on the floor. DCS #3 stated that R #1's son had moved the bedrail from the center of the bed to the end of the bed where R #1's head would be when [redacted] slept soon after it was put in place following [redacted] previous fall on 05/01/17.

K. On 08/06/17 at 9:40 am, during interview with DCS #4, she stated on 07/29/17 she heard DCS #2 call for help, then she heard DCS #2 call for help again, her voice was very shaky and DCS #4 knew something was really wrong. When DCS #4 walked into R #1's room, [redacted] was rolled completely off the bed and [redacted] body, including [redacted] face were completely covered with [redacted] blankets. [redacted] body was very close to the bed and she could not see [redacted] face due to being covered with the blankets. When the blanket was removed from R #1's face, [redacted] head was caught in the bed rail between the rail and the mattress. DCS #4 thinks R #1 choked to death due to having [redacted] head hung up in the bed rail and [redacted] face covered with the blanket. DCS #4 stated that R #1 had very weak upper body strength and she does not think [redacted] would have been able or would even have tried to free [redacted], [redacted] right arm was usually curled up next to [redacted] stomach. DCS lowered R #1 to the floor, laying [redacted] on [redacted] right side. DCS #4 confirmed that R #1 usually slept with [redacted] head

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at the end of the bed next to the window and where the bed rail had been placed. DCS #4 stated that it looked to her like [redacted] rolled over and caught [redacted] head (covered with blankets) inside the bed rail. 911 was called, DCS #3 tried CPR, but was unsuccessful, the police and ambulance were called, [redacted] was pronounced dead at the hospital.

L. Record review of R #1's Resident Notes dated 05/03/17 on the 11:00 pm-7:00 am shift, revealed that he called for assistance because [redacted] feet were wrapped up in [redacted] covers and then a second time to have the DCS straighten out [redacted] legs.

M. On 08/05/17 at 1:47 pm, during interview with the HM, she confirmed that R #1 would, at times, wrap [redacted] up in [redacted] blankets.

Findings related to bed rails
N. Record review of the facility's Incident Reporting form dated 05/01/17 revealed that after R #1's fall with injury on 05/01/17, a meeting was held with R #1's family to discuss fall prevention interventions that could be used. The report stated that the Administrator had suggested that a wedge mattress and/or a crash mat be used, however, the family decided to use a single bar removable bed rail to prevent [redacted] from rolling out of bed and to assist [redacted] as a support bar when [redacted] gets out of bed. The report stated that the bed rail/support bar was to be placed at mid-mattress distance from the head/foot of the bed.

O. On 08/04/17 at 3:50 pm, during interview with DCS #s 1 and 2, they stated that approximately 3 months ago, R #1 rolled out of bed and a bedrail was installed on [redacted] bed. [redacted] family hoped the bed rail would let [redacted] know [redacted] was near the edge of the bed and roll back over.

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A 033	Continued From page 25 P. On 08/04/17 at 4:07 pm, during interview with the Administrator and HM, the Administrator confirmed that after R #1's fall on 05/01/17, he met with his family and recommended that a scooped mattress or a mat on the floor be used instead of the bed rail. However, the family wanted the bedrail so R #1 could use it to reposition [redacted] confirmed that the facility went along with the family's decision and the bedrail was put in place. Q. Record review of R #1 resident chart revealed no documentation of a physician's order for R #1 to have a bedrail. R. Record review of R #1's ISP dated 07/24/17, revealed no documentation that a bedrail was being used. S. On 08/05/17 at 11:00 am, during interview with DCS #3 in R #1's room, she confirmed that the bedrail was at the end of the bed where R #1's head would be when [redacted] was asleep. DCS #3 stated that R #1's head (from jawbone up) was inside the bar of the bedrail and both [redacted] arms and legs were tangled up in the blankets, with [redacted] body hanging off the bed, and [redacted] feet on the floor. DCS #3 stated that R #1's son had moved the bedrail from the center of the bed to the end of the bed where R #1's head would be when [redacted] slept. T. On 08/05/17 at 1:47 pm, during interview with the HM, she reported that she gave R #1's son the bedrail that had been left by a previous resident and she thinks that is when the son installed it on the bed and placed it at the end of the bed where R #1's head would be when [redacted] slept, instead of the middle of the bed, as it was	A 033		

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A 033	Continued From page 26	A 033		

stated it would be in the meeting with the family on 05/01/17. The HM confirmed that that at no time did she speak to the son about the bed rail not being placed in the middle of the bed. She also confirmed that there was no documentation in R #1's ISP dated 07/24/17 regarding the use of a bed rail.

U. On 08/08/17 at 9:32 am, during interview with the Administrator, he confirmed that the facility had not received a physician's order for R #1 to have a bed rail and stated that he did not know they needed one.

Findings related to q2hr checks and staff rounds.
V. Record review of the New Resident Risk Agreement Contract dated 07/15/16 states that R #1 has difficultly in the area of "Fall Risk".

W. Record review of R #1's ISP dated 07/24/17 revealed that q2hr checks were suppose to be conducted by the DCS to ensure his safety and well-being and that [redacted] was at risk for falls.

X. On 08/04/17 at 3:50 pm, during interview with DCS #s 1 and 2, they stated that R #1 was to have q2hr checks.

Y. On 08/05/17 at 9:14 am, during interview with DCS #1, she stated on 07/28/17 that DCS #2 did the 11:00 pm, rounds and that during her shift (11:00 pm to 7:00 am), she did not go into R #1's room and check on [redacted] because she was doing cleaning that night, and R #1 never called for assistance, which [redacted] usually does. DCS #1 stated that when she and DCS #2 went to check on R #1 at approximately 7:10 am, they found [redacted] with [redacted] head in the bar of the bed rail and [redacted] body was hanging on the floor, and [redacted] looked

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A 033	Continued From page 27 deceased. She stated that she did not know that q2hrs meant to do a visual check on the resident Z. On 08/05/17 at 10:00 am, during interview with DCS #2, she stated that she worked the 11:00 pm-7:00 am shift beginning on 07/28/17. DCS #2 stated that she came on shift at 11:00 pm, the off-going shift were DCS #s 3 and 5. DCS #2 stated that she did not do the 11:00 pm rounds because she was told everyone was sleeping. DCS #2 stated that rounds are suppose to be done every 2 hours, but she usually only checks on residents when alerted by a resident using their call button or when checking on another resident in the same room. She stated that when checking on another resident around 2:30 am, she heard R #1 snoring, but did not actually see him. On 07/29/17 at 7:00 am, she was doing rounds with DCS #4 and she decided to check on R #1 before she left. DCS #2 stated that she and DCS #1 went to check on R #1 together. DCS #2 says that when she walked into R #1's room she saw [redacted] head stuck in the bed rail and [redacted] body hanging off the bed with the blankets holding [redacted] up. After she called for help, DCS #s 3 and 4 came in and helped lift R #1 off the bed rail and onto the floor. DCS #2 stated that she does not know if [redacted] was still breathing and did not hear [redacted] gasp when they put [redacted] on the floor. AA. On 08/05/17 at 1:47 pm, during interview with the HM, she confirmed that R #1's ISP stated that the [redacted] required q2hr checks by the DCS to ensure [redacted] safety and well-being. She also confirmed that when the DCS does a q2hr check, they need to be doing an actual visual check of the resident. She also confirmed that the offgoing and oncoming DCS are suppose to due rounds and check on all residents together each shift.	A 033		

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Findings related to information exchanged at shift report and computer documentation.
BB. Record review of the facility Incident Report dated 07/28/17, revealed that R #1 started to fall, was caught by DCS #6 and lowered to floor. R #1 was checked for injuries and then while being assisted into a wheelchair, [redacted] lost [redacted] balance again before sitting down in the chair. R #1 had no complaints of pain, seemed to be fine, and was checked by [redacted] home health nurse.

CC. Record review of the 24-Hour Observation Log dated 07/28/17 at 2:55 pm, revealed documentation in the computer that R #1 was not feeling good in the morning, had thrown up early in the morning when taking [redacted] pills and started gagging, [redacted] did not eat breakfast and did not eat lunch until about 1:00 pm. It was noted that while coming out of [redacted] room for lunch, R #1 lost [redacted] balance and fell, [redacted] was assisted to a wheelchair, ate a bit of soup, then went to [redacted] room. Management, daughter, and nurse were called.

DD. Record review of the 24-Hour Observation Log dated 07/29/17 at 5:06 am, DCS #1 noted R #1 was asleep at 1:00 am, 3:00 pm (should be 3:00 am), and was still asleep at 5:00 am, and that R #1 slept all night. This note appears to have been written on top and at the end of the previous note.

EE. On 08/05/17 at 9:14 am, during interview with DCS #1, she stated that nothing was passed on by the 3 pm-11 pm shift DCS #s 3 and 5, that R #1 had fallen and been sick during the day on 07/28/17 when they meet for shift report, so neither she or DCS #2 were aware he had been sick until the 7 am-3 pm shift, when DCS #4 came on and asked how R #1 was doing. DCS #1 also stated that she was just told that she has

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A 033	Continued From page 29	A 033		

been documenting incorrectly in the computer and she does not remember checking the computer when she came on shift.

FF. On 08/05/17 at 10:00 am, during interview with DCS #2, she stated that information regarding R #1 falling and being sick earlier that day [07/28/17] was not passed on during shift report.

GG. On 08/05/17 at 11:00 am, during interview with DCS #3, she reported that when she clocked in on 07/28/17 at 3:00 pm, she was told by the DCS on the 7 am-3 pm shift that R #1 had fallen earlier in the day, was weak, and had not eaten much [redacted] R#1 is usually able to get up with [redacted] walker and assist the DCS with transfers from [redacted] chair to [redacted] bed, but was not able to assist with when DCS staff came to transfer [redacted] to [redacted] bed. DCS #3 reported that R #1 was talking and, except for being weak, seemed ok. DCS #3 stated that she last checked on R #1 during the 11:00 pm rounds. DCS #3 stated that she does not think she reported to DCS #s 1 and 2 that R #1 had fallen earlier in the day and was weak.

HH. On 08/06/17 at 9:15 am, during interview with the Administrator, he confirmed that the DCS had multiple opportunities to know that R #1 had fallen, been weak, and not feeling well on 07/28/17 and apparently failed to do any of the following:

1. Resident rounds with off-going/on-coming DCS.
2. Shift report with off-going/on-coming DCS.
3. Computer notes, that are suppose to be read when coming on shift.
4. Completing q2hr checks on resident.

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A 035	Continued From page 30	A 035		
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 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	A 035		

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A 035	Continued From page 31 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 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	A 035		

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A 035	Continued From page 32 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. 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:	A 035		

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A 035	Continued From page 33 (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 (3) (4) (5) (16) 17) Based on record review and interview the facility failed to ensure for 4 residents (R #s 1-4) of 4 (R #s 1-4) residents whose Medication Administration Records (MARs) were reviewed for compliance included: 1. Both the brand/generic names of the medication. 2. The diagnosis/reason for the medication, 3. The Initals of the Direct Care Staff (DCS) who assisted residents with PRN (as needed) medications. 4. The results of PRN medications were	A 035		

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documented in the notes.
5. The physicians name and contact information.

If the MARs do not include all the required information, then residents may be at risk of harm or illness, and need medical treatment if medication errors occur because vital information is missing on the MAR. The findings are:

Findings related to R #1
A, Record review of R #1's [redacted] 2017 MAR revealed it did not include both the brand/generic names listed for the following medications:

[redacted]

Finding related to R #2
B. Record review of R #2's [redacted]/17 to [redacted]/17 MAR revealed it did not include:

[redacted]

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[redacted]

Findings related to R #3
C. Record review of R #3's [redacted]/17 to [redacted]/17 MAR revealed it did not include:

[redacted]

Findings related to R #4
D. Record review of R #4's [redacted]/17 to [redacted]/17 MAR revealed it did not include:

[redacted]

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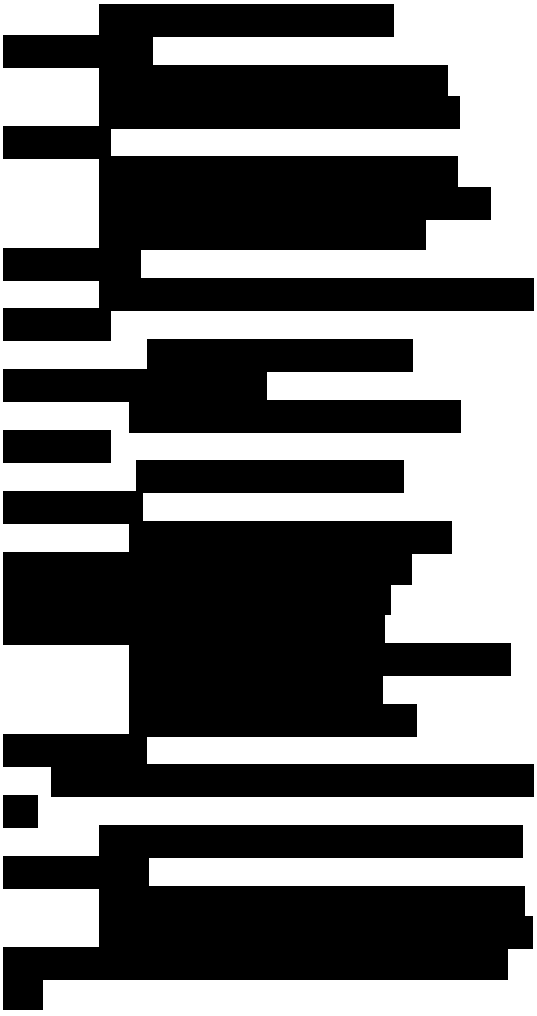

E. On 08/06/17 at 12:02 pm, during interview with the Administrator and House Manager, they confirmed the above listed vital information for R #s 1-4 was not included.

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A 049	Continued From page 37	A 049		
A 049	7 NMAC 8.2.49 Doors DOORS: A. No door in any means of egress shall be locked against egress when the building is occupied. (1) Exit doors may be provided with a night latch, dead bolt, or security chain, provided these devices are operable from the inside, by any occupant, without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed forty-eight (48) inches above the finished floor. (2) If locks are not readily operable by all occupants within the building, the locks must: 1) unlock upon activation of the fire detection or sprinkler system and 2) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written approval from the building, fire and licensing authorities having jurisdiction. B. All exit doors shall have a minimum width of thirty-six (36) inches. (1) Facilities with a capacity of ten (10) or more residents shall have exit doors leading to the outside of the facility that open outward. (2) Facilities with a capacity of fifty (50) or more residents must provide panic hardware at the exit doors. (3) No door or path of travel to a means of egress shall be less than twenty-eight (28) inches wide. C. All resident sleeping room doors must be at least one and three-quarters (1 3/4) inch solid core construction. D. Bathroom doors may be twenty-four (24) inches wide. Facilities with four (4) or more residents shall have at least one bathroom for every eight (8) residents with a door clearance of thirty-six (36) inches for access by persons with	A 049		

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A 049	Continued From page 38 disabilities. E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside. F. All doors shall readily open from the inside. G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms. [7.8.2.49 NMAC - Rp, 7.8.2.50 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.49 F Based on observation and interview, the facility failed to ensure that all doors could be opened from the inside with one motion when locked. This deficient practice has the potential for 12 (R #s 1-12) residents listed on the resident census, provided by the House Manager (HM) on 08/04/17, to be at risk of injury or harm if their room, bathroom, and exit doors are locked and cannot be opened with one motion in the event of a fire, loss of power, or an emergency that requires evacuation. The findings are: A. On 08/06/17 at 8:20 am, during observation, the door handle on the door in Room #10 was observed to have a lock that would not unlock with one motion. B. On 08/06/17 at 8:43 am, during observation, the door handle on the door in Room #2 was observed to have a lock that would not unlock with one motion. C. On 08/06/17 at 8:43 am, during observation, the door handle on the the public bathroom across from the kitchen, was observed to have a lock that would not unlock with one motion.	A 049		

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A 049	Continued From page 39 D. On 08/06/17 at 8:43 am, during observation, the door handle on the exit door in the pantry, was observed to have a lock that would not unlock with one motion. E. On 08/06/17 at 8:45 am, during interview with the Administrator, he confirmed that the locks on Room #s 2 and 10, public bathroom, and exit doors in pantry, would not unlock with one motion. He also stated that all of the doors in the facility had locks on them that would not unlock with one motion.	A 049		
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 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	A 069		

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A 069	Continued From page 40 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 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 "	A 069		

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A 069	Continued From page 41 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) 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	A 069		

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A 069	Continued From page 42 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 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	A 069		

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A 069	Continued From page 43	A 069		

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 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

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A 069	Continued From page 44 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 C Based on record review and interview, the facility failed to ensure that 1 (DCS # 4) of 1 (DCS # 4) Direct Care Staff employed for over one year, had completed an additional 12 hours of dementia specific training. This deficient practice has the potential for residents receiving dementia care and services to be at risk of not receiving the individual (physical, mental, social) care and services residents with Dementia (a decline in memory or other thinking skills) require because the DCS have not completed the required annual specialized dementia training. The findings are: A. Record review of DCS #2's training file revealed, no documentation that 12 hours of dementia training was completed. B. Record review of DCS #4's training file revealed, 1. Annual Training for Alzheimer's - 12 hours of Continuing Education document dated 01/27/17 and signed by DCS #4, does not state who conducted the training and does not have any check/initial marks next to training titles. 2. Alzheimer's Specific Training document dated 01/27/17, states that only 3 trainings for dementia took place on 1/27/17. C. On 08/06/17 at 10:45 am, during an interview with the Administrator, he confirmed that DCS #2 and #4's documents are not trainings, they are check lists for Dementia trainings. He could not	A 069		

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A 069	Continued From page 45 confirm whether the trainings took place.	A 069		