STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2216	A. BUILDING: _____ B. WING _____	C 11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE SPIRE ASSISTED LIVING OF RIO RANCHO	1001 24TH ST RIO RANCHO, NM 87124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited as a result of a Full-Onsite/Complaint survey completed on 11/22/17 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake NM#30218 was unsubstantiated with deficiencies cited.	A 000		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC;	A 020		

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A 020	Continued From page 1 (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require	A 020		

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A 020	Continued From page 2 continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in	A 020		

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A 020	Continued From page 3 writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010]	A 020		

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A 020	Continued From page 4 This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) (12) B (9) C (1) D (1) Based on record review and interview the facility failed to ensure for 5 (R #s 3-7) of 5 (R #s 3-7) residents that: 1. The Admission/Discharge Agreements included a refund provision in case of death. 2. The Admission agreement may be terminated "if" an appropriate placement is found. 3. Does not Admit an individual that requires twenty-four (24) continuous nursing-care with a diagnosis that requires isolation. 4. An Admission/Retention team meeting is convened prior to admitting/retaining residents on Home Health Care. 5. Coordination of care with the hospice/home health provider was documented on the Individual Service Plan (ISP). These deficient practices have the potential for the residents to be at risk of harm if: 1. Monies paid to the facility are not being correctly refunded to the resident's estate after death. 2. The residents are being discharged before an appropriate placement was found. 3. The facility admits a person that requires 24-hour continuous nursing-care and needs isolation procedures. 4. The residents are needing a higher level of care and services than staff can provide, if a team meeting is not held prior to admitting or retaining a resident on home healthcare services or requiring a higher level of care then facility would normally provide.	A 020		

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A 020	Continued From page 5 5. The Direct Care Staff (DCS) do not know what services they are to provide and what services the hospice agency will provide. The findings are: A. Record review of R #3's (hospice start date [redacted]17) admission agreement dated [redacted]/16 revealed that: 1. It does not state the refund provision in case of death. 2. It does not state that the agreement can be terminated "if" appropriate placement has been found for the resident. 3. The ISP (no date) was not reviewed or up-dated to include hospice services and for coordination of care between the facility and the hospice agency when resident was admitted to hospice. B. Record review of R #'s 4 admission agreement dated 11/22/16 revealed that: 1. It does not state the refund provision in case of death. 2. It does not state that the agreement can be terminated "if" appropriate placement has been found for the resident. C. Record review of R #'s 5 (hospice start date [redacted]/17) admissions agreement dated [redacted]/17 revealed that: 1. It does not state the refund provision in case of death. 2. It does not state that the agreement can be terminated "if" appropriate placement has been found for the resident. 3. The ISP dated 02/27/17 was not reviewed and up-dated to include hospice services and for coordination of care between the facility and the hospice agency when resident was admitted to hospice.	A 020		

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A 020	Continued From page 6 D. Record review of R #'s 6 admissions agreement dated 08/05/17 revealed that: 1. It does not state the refund provision in case of death. 2. It does not state that the agreement can be terminated "if" appropriate placement has been found for the resident. E. Record review of R #'s 7 (admitted to Home Healthcare on 10/06/17) admissions agreement dated 10/01/17 revealed that: 1. It does not state the refund provision in case of death. 2. It does not state that the agreement can be terminated "if" appropriate placement has been found for the resident. 3. No documentation that a team meeting between the facility, (POA) Power of Attorney and Home Health agency had been convened prior to his admission to Home Healthcare services. 4. Hospital Medical record dated 10/08/17, states that R #7 has [redacted] Hospital Medical Record dated [redacted] 17, states Diagnosis: [redacted] F. On 11/16/17 at 5:15 pm, during an interview with the House Manager, she confirmed the following: 1. The termination agreement for R #s 3-7 for termination incorrectly states for the section for death "The contract rate will be charged for the entire calendar month regardless of what portion of the month your unit is occupied." 2. The admission agreement for termination for R #s 3-7 does not have the statement "If an	A 020		

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A 020	Continued From page 7 appropriate placement has been found for the resident." 3. The ISPs for R #s 3 and 5 were not reviewed and updated to include hospice services and for coordination of care between the facility and the hospice agency when residents were admitted to hospice. G. On 11/22/17 at 9:30 am, during an interview with the Administrator, she confirmed that R #7 did have a diagnosis of [redacted] and [redacted] was isolated to [redacted] room. H. On 11/22/17 at 12:30 pm, during an interview with the Administrator, she confirmed for R #7 that there was no team meeting between the facility, power of attorney/resident and home health care agency convened prior to being admitted to home healthcare services on 10/06/17.	A 020		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at	A 025		

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A 025	Continued From page 8 a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC,	A 025		

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A 025	Continued From page 9 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 B Based on record review and interview the facility failed to ensure for 3 (R #s 3, 5, and 7) of 5 (R #s 3-7) residents whose evaluations/assessments were reviewed for compliance were reviewed and updated when there was a change in condition. This deficient practice has the potential for residents to not receive the increased level of care and services needed if the evaluations/assessments have not been updated to reflect their increased level of care. The findings are: A. Record review of R #3's evaluation/assessments dated 03/03/17 and 09/12/17 revealed that the evaluation/assessments were not reviewed or updated when she had a change in condition and was admitted to hospice services on [redacted]/17. B. Record review of R #5's evaluation/assessments dated 09/12/17 revealed that the evaluation/assessments were not reviewed and updated when [redacted] had a change in condition and was admitted to hospice services on [redacted]/17. C. Record review of R #7's evaluation/assessment dated 10/14/17 revealed that the evaluations/assessments were not reviewed and updated when [redacted] had a change in	A 025		

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A 025	Continued From page 10 condition and was admitted to home healthcare services on 10/06/17 and diagnosed with [redacted] 17. D. On 11/16/17 at 5:15 pm, during interview with the House Manager, she confirmed that the evaluations/assessments for R #s 3 and 5 were not updated when they had a change in condition. E. On 11/22/17 at 12:30 pm, during interview with the Administrator, she confirmed that R #7's evaluations/assessments were not updated for when he had a change in condition and was diagnosed with [redacted] and admitted on home health services.	A 025		
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	A 026		

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A 026	Continued From page 11 the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (1) (3) (B) (7) Based on Record review and interview the facility failed to ensure for 3 (R #s 3, 4 and 5) of 3 (R #s 3, 4 and 5) residents whose Individual Service Plans (ISPs) reviewed for compliance: 1. Were reviewed and revised when a change in condition occurred. 2. Included documentation of coordination of care with hospice/healthcare services providers. 3. Included expected goals and outcomes of services provided. This deficient practice has the potential for residents to be at risk of harm if they do not	A 026		

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A 026	Continued From page 12 receive the appropriate care and assistance they need as changes in their health status occurs. The findings are: A. Record review of R #3's (admissions date [redacted]/16) file revealed that the last ISP (no date) revealed it: 1. Was not reviewed/revised at a minimum of six months. 2. Was not updated when a change in condition occurred and admitted to hospice services on [redacted]/17. 3. Did not include coordination of care between the facility and hospice agency. 4. Was missing the required goals and outcomes. B. Record review of R #4's file revealed that the ISP dated 07/10/15 revealed it: 1. Was not reviewed/revised at a minimum of six months. 2. Was missing the required goals and outcomes. C. Record review of R #5's ISP dated 02/27/17 revealed it: 1. Was not reviewed/revised at a minimum of six months. 2. Was not up dated when a change in condition occurred and was admitted to hospice services on [redacted]/17. 3. Did not included coordination of care between the facility and hospice agency. 4. Was missing the required goals and outcomes. D. On 11/16/17 at 5:15 pm, during an interview with the House Manager, she confirmed that R #s 3, 4 and 5 ISPs were not revised at a minimum of six months and/or when changes in condition	A 026		

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A 026	Continued From page 13 occurred (admission to hospice), and did not include goals and outcomes. She also confirmed that R #s 3 and 5's ISPs did not include coordination of care between the facility and the hospice agency.	A 026		
A 033	7 NMAC 8.2.33 Resident Rights 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,	A 033		

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A 033	Continued From page 14 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; (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	A 033		

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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;
(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

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A 033	Continued From page 16 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: NMAC 7.8.2.33 (D) (1) (4) The facility failed to ensure that residents were provided with a safe and sanitary environment failing to implement interventions to protect residents when a resident (R #7) was diagnosed with [redacted] This deficient practice resulted in an Class B Deficiency being identified on 11/21/17 at 1:46 pm, for the infection control concerns. The Administrator and House Manager were notified at this time and a Plan of Removal requested. The facility took corrective action by providing an acceptable Plan of Removal which included; Policy and Procedures have been developed to address C.Diff in specific as follows: 1. All staff including those who were currently on the floor will be trained by a Registered Nurse on Universal Precautions. Universal Precaution training will occur at orientation and yearly to ensure that all staff are trained on Universal Precaution and the Protocol for C.Diff. 2. Visitors and family members have been trained on Isolation Precaution as of 4:49 pm on 11/21/17. 3. Supplies will be kept outside R #7's room to include: gowns, masks, gloves and a portable sink if necessary for immediate access to enable hand washing.	A 033		

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4. Staff are to gown up place double gloves on and mask, enter room to complete task.
5. Before leaving room, take gloves, gown and mask off and place items in receptacle located in the resident room.

Policy for resident who has received a negative sample as follows:
1. Remove the resident from the room.
2. Shower the resident in a clean shower with clean clothes that have not been exposed to C. Diff.
3. Begin the terminal Cleaning Process as follows:
a. In complete gown up, remove the linen and dispose of in a tied trash bag. Dispose in outside trash making sure not to touch any object while going to the trash, call for the assistance of staff to assist with opening door or entering code to outside door to prevent cross contamination. Return and wash hands.
b. Gather all clothes and remove in a tied bag and dispose of with the same process as above or give to family for immediate removal.
c. Remove mattress from bed space and discard if it has been exposed.
d. Begin sanitation process: Gown up as noted above before entering room.
e. Use approved bleach and/or approved anti-spore product and clean all surfaces, complete a mop up with bleach water, complete cleansing of porous areas as well or remove porous surfaces. Staff must pay attention to the amount of time that the bleach or product must stay on wet: example 3-10 minutes.

Hand Washing Procedures as follows:
1. Wash hands before entering room, place gloves and then enter room.
2. Wash hands when exiting bedroom

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immediately, hands must not be washed in the resident's room, use sink out of bedroom.

On 11/23/17 at 12:21 pm, the Plan of Removal was accepted. The Administrator was notified at this time that the Class B Deficiency was lifted.

Based on observation, record review and interview the facility failed to ensure for 1 (R #7) of 1 (R#7) resident with a contagious infection to:

1. Provide a hygienically clean odor free environment by taking a large bag of open used disposable adult diapers some from the room of R #7 around the facility while checking resident's in their rooms during the night shift.

2. Provide a safe and sanitary environment by failing to implement interventions to protect residents when a resident was diagnosed with [redacted]

3. Treat a resident with courtesy, respect, dignity and compassion when a Direct Care Staff (DCS) dressed a resident in adult briefs without consent and when resident is continent.

This deficient practice has the potential for all residents to be at risk of harm or illness:

1. If residents breathed in the odor of urine, feces, and bacteria from an open bag of soiled adult briefs.

2. From the spread of a contagious infection throughout the facility.

3. If residents develop skin conditions because Direct Cares Staff are unaware that the resident is wearing adult briefs that has not been documented on the evaluation. The findings are:

Findings related to Odor:

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A 033	Continued From page 19 A. On 11/16/17 at 3:25 am, during observation, Direct Care Staff (DCS) #7 was observed dragging an open large bag containing soiled adult briefs going from room to room down the hallways of the facility. B. On 11/16/17 at 4:35 am, during interview with DCS #7, she confirmed that she was dragging an open bag of soiled adult briefs in the hallways of the facility. Findings related to [redacted] C. Record review of Hospital Medical Record dated 10/08/17 revealed that R#7 has a diagnosis of [redacted] D. On 11/21/17 at 9:52 am, during observation of R #7's room (being used for isolation room), it was observed not to have a sink to wash hands, for personal care, and hygiene. E. On 11/21/17 at 10:00 am, during an interview with the House Manager, she confirmed that R #7's room does not have a sink. F. On 11/21/17 at 10:13 am, during observation and interview, DCS #5 was observed leaving R #7's room (that does not have a sink for washing hands) without gloves on and walked across to the community bathroom and pushed the door open with her left hand. She confirmed that she touched the door to the community bathroom without washing her hands before she touched the community bathroom door. G. On 11/21/17 at 10:13 am, during observation	A 033		

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and interview, DCS #4 was observed leaving R #7's room with no gloves on, dropping the resident's trash onto the floor and leaving it, walking across to the community bathroom and touching the handle on the door with her left hand, and touching the light switch with her right hand. She confirmed that she touched the handle on the door and light switch in the community bathroom before washing her hands.

H. On 11/21/17 at 10:20 am, during observation and interview, DCS #4 was observed to picked up the trash bag from R #7's contaminated room with a piece of tissue paper with her left hand, using the code pad to open the front door, going to the trash bin outside and returning to the facility entering using the code pad. Walked to the door of the salon and stood there without going to wash her hands. She confirmed that she did not wash her hands immediately after touching a bag of trash from a contaminated room and the trash bin outside when she came back into the facility.

Findings related to resident dignity:

I. On 11/21/17 at 9:52 am, during an interview with R #7, [redacted] stated that [redacted] did not know why [redacted] is in adult briefs because [redacted] can use the restroom with assistance and went on to say "They just put them on me."

J. Record review of R #7's Evaluations dated 10/01/17 and 10/14/17 revealed, that the resident is not [redacted]

K. On 11/21/17 at 10:30 am, during an interview with the House Manager, she stated that R #7 is in adult briefs because [redacted]

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A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to	A 034		

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purchase medications from any particular pharmacy.
(7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99.
(8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document:
(a) the type and strength of the schedule II through IV drugs;
(b) the date and time staff assisted with self-administration;
(c) the resident ' s name;
(d) the prescriber ' s name;
(e) the dose;
(f) the signature of the person assisting with delivery of the medication; and
(g) the balance of medication remaining.
(9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC.
(10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility.
B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance.
(1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are

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A 034	Continued From page 23 accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (8) (f) Based on record review and interview the facility failed to ensure that the Direct Care Staff (DCS) signed the controlled medication count sheet for 1 (R #8) of 4 (R #s 3, 5, 6 and 8) residents whose controlled medication records were reviewed for compliance. This deficient practice has the potential for residents to be at risk of harm if the DCS signatures are not on the controlled mediation count sheet, then the facility/residents may not be aware who has access to the controlled medications. The findings are: A. Record review of R #8's controlled medication record for [redacted]	A 034		

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A 034	Continued From page 24 [redacted]/17 to 11/15/17 revealed, missing signatures of the DCS assisting with medications. B. On 22/16/17 at 3:43 am, during interview with DCS #3, she confirmed that there were missing signatures from DCS on R #8's controlled medication record for [redacted]	A 034		
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.	A 035		

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A 035	Continued From page 25 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 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	A 035		

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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 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

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A 035	Continued From page 27 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: (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 A Based on observation and interview the facility failed to ensure that only a Licensed Nurse (LN) or Certified Health Care Provider (CHCP)	A 035		

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A 035	Continued From page 28 administer medications for 1 (R #5) of 1 (R #5) resident who cannot assist with the self-administration of medication. This deficient practice has the potential to cause serious illness or injury requiring emergency medical treatment and even death if unlicensed/non-qualified Direct Care Staff (DCS) incorrectly administers medications to residents that are not cognitively or physically able to assist with the self-administration of their medications. The findings are: A. On 11/21/17 at 11:55 am, during observation, DCS #6 was observed to crush R #5's mix them in yogurt, and feed the medication and yogurt to R #5. B. On 11/21/17 at 12:05 pm, during interview with DCS #6, she confirmed that she administered the medication to R #5 because [redacted] is not able to [redacted]	A 035		
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of	A 037		

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A 037	Continued From page 29 infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet. B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (2) (3) (10)	A 037		

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A 037	Continued From page 30 Based on observation and interview, the facility failed to ensure that: 1. Cleaning supplies were kept in a secured room or closet. 2. Clean laundry was kept separate from dirty laundry. 3. Clean Linens and clothes were stored correctly. The deficient practice has the potential for the 23 (R #s 1-23) residents identified on the resident census provided by the House Manager on 11/16/17, to be at risk of harm or injury if they were to ingest or spill cleaning supplies on their face or body and staff do not handle laundry with care to prevent the spread of infectious and communicable disease. The findings are: A. On 11/16/17 at 3:00 am, during observation of laundry rooms the following was observed: 1. Staff entered laundry room with dirty laundry thru clean laundry room door. 2. Clean and dirty laundry were on the floor in both laundry rooms. 3. Clean linens were stored in the dirty laundry room. 4. Laundry/chemical supplies were being stored unsecured and accessible to residents in both laundry rooms as follows: a. 3-35 lb (pound) tubs of laundry soap and one with no lid. b. 1-1 gallon bottle of disinfectant c. 1-1.17 gallon bottle of liquid laundry soap. B. On 11/16/17 at 3:38 am, during an interview with Direct Care Staff (DCS) #7, she confirmed that: 1. Staff entered laundry room with dirty laundry thru clean laundry room door.	A 037		

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A 037	Continued From page 31 2. Clean and dirty laundry were on the floor in both laundry rooms. 3. Clean linens were stored in the dirty laundry room. 4. Laundry/chemical supplies were stored unsecured and accessible to residents both laundry rooms.	A 037		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 B Based on observation and interview the facility	A 063		

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A 063	Continued From page 32 failed to ensure that 1 of 10 fire extinguishers had been inspected monthly to ensure proper working order in case of a fire. This deficient practice has the potential for all residents to be at risk of injury or death if there is a fire and the fire extinguishers do not work properly. The findings are: A. On 11/16/17 at 3:00 am, during a tour of the facility it was observed that 1 fire extinguisher was in the laundry room standing on a shelf and had not been checked since September 2010. B. On 11/16/17 at 3:05 am, during an interview with Direct Care Staff (DCS) #7, she confirmed that the fire extinguisher was standing on a shelf and had not been checked since September 2010.	A 063		
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC.	A 068		

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A 068	Continued From page 33 (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education	A 068		

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A 068	Continued From page 34	A 068		

requirements pursuant to 7.8.2.17 NMAC; and
(2) offer an ongoing employee psychological support program for end of life care issues.
C. Individual service plan (ISP) requirements.
(1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff.
(2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following:
(a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC;
(b) what services are to be provided;
(c) who will provide the services;
(d) how the services will be provided;
(e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process;
(f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and
(g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them.
(3) 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);

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A 068	Continued From page 35 (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. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the	A 068		

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coordination of services with the hospice agency.
(a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs.
(b) The assisted living facility shall receive information and communication from the hospice staff at each visit.
(i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.).
(ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation.
(c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members.
(d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator.
(i) The process may be informal or formal depending on the nature of the issue.
(ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified.
E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements:
(1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP;
(2) private visiting space:
(a) physical space for private family visits;
(b) accommodations for family members to

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A 068	Continued From page 37 remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.68 D (5) Based on record review and interview the facility failed to ensure for 2 (R #s 3 and 5) of 2 (R #s 3 and 5) residents who are receiving hospice services that their Individual Service Plans (ISPs) included documentation of coordination of care with the hospice provider. This deficient practice has the potential for all residents receiving hospice services, to be at risk of not receiving the higher level of care and services needed if the Direct Care Staff (DCS) do not know what services hospice will provide and/or what services they are to provide for the resident. The findings are: A. Record review of R #3's ISP (undated) revealed that it did not include coordination of care between the facility and the hospice agency when resident was admitted to hospice services on [redacted]/17. B. Record review of R #5's ISP dated 02/27/17 revealed that it did not include coordination of care between the facility and the hospice agency when resident was admitted to hospice services	A 068		

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A 068	Continued From page 38 on [redacted]/17. C. On 11/16/17 at 5:15 pm, during interview with the House Manager, she confirmed that the ISPs for R #s 5 and 7 did not include coordination of care between the facility and the hospice agency when residents were admitted to hospice services.	A 068		