STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2165	A. BUILDING: _____ B. WING _____	C 09/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA ANGELINA LLC	9977 BUCKEYE NW ALBUQUERQUE, NM 87114

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A 000	Initial Comments The following deficiencies were cited during a Full-Onsite/Complaint survey completed on 09/09/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint #NM 34551 was unsubstantiated with deficiencies cited.	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC.	A 016		

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A 016	Continued From page 1 B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010]	A 016		

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A 016	Continued From page 2 This REQUIREMENT is not met as evidenced by: 7.8.2.16 B (3) (7) 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the	A 016		

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A 016	Continued From page 3 provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per	A 016		

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A 016	Continued From page 4 instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: . . . D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the	A 016		

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A 016	Continued From page 5 Department. . . . E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall	A 016		

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A 016	Continued From page 6	A 016		

maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules.
(1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification.
(2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes.

Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS):
1. Were cleared by the Employee Abuse Registry (EAR) prior to hire.
2. Fingerprints and application were submitted to Criminal History Screening Program (CCHSP) within 20-days after hire.

This deficient practice has the potential for all 4 (R #s 1-4) residents identified on the census provided by the Administrator on 09/09/19 to be risk for injury or harm if the residents are being provided care by staff who may have a prior history of abuse, neglect or exploitation of residents.

The findings are:

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A 016	Continued From page 7 A. Record review of DCS #1's employee file (hire date 05/16/13) revealed no documentation of the submission date of the EAR/CCHSP application and fingerprints. B. Record Review of DCS #2's employee file (hire date 07/19/16) revealed no documentation that the EAR/CCHSP application and fingerprints were ever submitted. C. On 09/09/19 at 1:20 pm, during an interview, the Administrator confirmed for DCS #s 1-2 that their: 1. EAR clearances were not received prior to hire. 2. Fingerprints and applications were not submitted to the CCHSP within 20-day after hire.	A 016		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling;	A 017		

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A 017	Continued From page 8 (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 A C Based on record review and interview the facility failed to ensure that the Direct Care Staff (DCS) received all required supervised, orientation, and annual trainings. This deficient practice has the potential for all 4 (R #s 1-4) residents listed on the census provided by the Administrator on 09/09/19, to be at risk of harm or injury if staff do not receive training on the proper methods of providing care and services. The findings are: A. Record review of DCS #1s (05/16/13) staff file	A 017		

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A 017	Continued From page 9 revealed no documentation of receiving the following training during orientation: 1. 16 hours of supervised training before providing direct care, 2. First aid training 3. Confidentiality of records and resident information 4. Smoking policy for staff, residents, and visitor B. Record Review of DCS #2s (07/19/16) staff file revealed no documentation of receiving the following: 1. 16 hours of supervised training before providing direct care 2. First aid training 3. Confidentiality of records and resident information 4. Smoking policy for staff, residents, and visitor 5. Annual training to include a. fire safety and evacuation b. first aid c. safe food handling practices i. instructions in proper storage ii. preparation and serving food iii. safety in food handling iv. appropriate personal hygiene v. infectious and communicable disease control d. confidentiality of records and resident information e. infection control f. resident rights g. reporting requirements for abuse, neglect, or exploitation in accordance with 7.1.1.3 NMAC h. smoking policy for staff, residents and visitors i. methods to provide quality resident	A 017		

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A 017	Continued From page 10 care j. emergency procedures k. medication assistance l. the proper way to implement a resident ISP for staff who assist with ISP's. C. On 09/09/19 at 1:30 pm, during an interview with the Administrator, he confirmed there was no documentation in DCS #s 1-2 staff files of receiving the above listed trainings.	A 017		
A 018	7 NMAC 8.2.18 Policies POLICIES: The facility shall have and implement written personnel policies for the following: A. staff, private duty attendant and volunteer qualifications; B. staff, private duty attendant and volunteer conduct; C. staff, private duty attendant and volunteer training policies; D. staff and private duty attendant and volunteer criminal history screening; E. emergency procedures; F. medication administration; G. the retention and maintenance of current and past personnel records; and H. facilities shall maintain records and files that reflect compliance with NM and federal employment rules. [7.8.2.18 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.18 C D G	A 018		

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A 018	Continued From page 11 Based on record review and interview, the facility failed to have all the required written personnel policies for staff and volunteers. This deficient practice has the potential for all 4 (R #s 1-4) residents identified on the census provided by the Administrator on 09/09/19, to be at risk of harm or injury if staff are not trained or aware of the correct way to implement facility policies and procedures that affect the safety and welfare of the residents. The findings are: A. Record review of the facility's Policy and Procedure Manual revealed that the following required personnel policies were missing: 1. Staff, private duty attendant, and volunteer training policies. 2. Staff and private duty attendant and volunteer criminal history screening 3. The retention and maintenance of current and past personnel records. B. On 09/09/19 at 1:35 pm, during an interview, the Administrator confirmed that there were no written facility personnel policies for the findings listed above.	A 018		
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 020		

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A 020	Continued From page 12 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; (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;	A 020		

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A 020	Continued From page 13 (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 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;	A 020		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 14 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 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.	A 020		

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	2165	A. BUILDING: _____ B. WING _____	C 09/09/2019

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A 020	Continued From page 15 (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] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) (7) (10) (12) (a-e) (i-iii) Refer to Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:	A 020		

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A 020	Continued From page 16	A 020		

SECTION 1. A new section of the Public Health Act is enacted to read:

"ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.--

A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings.

B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them.

C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health."

SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

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A 020	Continued From page 17 Based on record review and interview the facility failed to ensure that 4 (R #s 1-4) of 4 (R #s 1-4) residents whose Admission/Discharge Agreements were reviewed for compliance included the following information: 1. A refund provision in case of death that is in compliance with 7.8.2.20 and Senate Bill (SB) 0335 - 2013. 2. Written description of resident rights 3. Notification of right and responsibilities regarding incident reporting 4. That the admission agreement may be terminated if an appropriate placement is found, 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 make, unless the resident requests 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, e) termination without 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; iii) the safety and health of other residents and staff in the facility are endangered. These deficient practices have the potential for all residents to be at risk of harm if: 1. Upon death the resident's estate/responsible party does not receive a refund of the monies owed or are aware of	A 020		

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A 020	Continued From page 18	A 020		

additional charges that may be owed.

2. Residents or Power of Attorney's (POA'S) do not understand what their rights are

3. Residents or POA's do not understand their rights and responsibilities regarding the reporting of suspected abuse, neglect or exploitation.

4. Residents or POA's do not know the circumstances/requirements required for termination of agreement by the facility.

The findings are:

A. Record review of R #'s 1-4 Admission/Discharge Agreements revealed, the following missing information:

1. A refund provision in case of death that is in compliance with 7.8.2.20 and Senate Bill (SB) 0335 - 2013.

2. Written description of resident rights

3. Notification of right and responsibilities regarding incident reporting

4. The admission agreement may be terminated if an appropriate placement is found, 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 make, unless the resident requests 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,

e) termination without notice is permitted in emergency situations for the following reasons:

i) the transfer or discharge is

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A 020	Continued From page 19 necessary for the resident's safety and welfare; ii) the resident's needs cannot safely be met in the facility; iii) the safety and health of other residents and staff in the facility are endangered. B. On 09/09/19 at 1:46 pm, during an interview, the Administrator confirmed that above listed information were missing from R #s 1-4 Admission/Discharged Agreements.	A 020		
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific	A 022		

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A 022	Continued From page 20	A 022		

requirements by the local health authority, a copy of that determination must also be maintained;
(7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction;
(8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks;
(9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSES) rating, if applicable;
(10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of emergencies:
(a) an emergency that affects just the facility; and
(b) a region/area wide emergency;
(11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC);
(12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and
(13) vaccination records for pets in the facility.
B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority:

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A 022	Continued From page 21 (1) a copy of the facility license; (2) employee personnel records, including an application for employment, training records and personnel actions: (a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC; (b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and (3) a copy of all waivers or variances granted by the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas; (7) accommodation of resident ' s pets; and (8) resident use of electric blankets and appliances. D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas: (1) actions to be taken in case of accidents or emergencies; (2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission; (3) policy for medication errors; (4) method of staying informed when residents	A 022		

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A 022	Continued From page 22 are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.); (5) the handling of resident's funds, if the facility provides such services; (6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (12) admission agreement; (13) admission records; (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator	A 022		

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A 022	Continued From page 23 with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (10) (a-b) Based on record review and interview the facility failed to ensure that there were written Emergency Plans for emergencies that affects just the facility and a community wide disaster that include: 1. Evacuation process 2. Persons to be notified 3. Emergency equipment 4. Evacuation routes 5. Refuge areas 6. Responsibilities of personnel during emergencies 7. A list of transportation resources These deficient practices have the potential for all 4 (R #s 1-4) residents listed on the census provided by the Administrator 09/09/19, to be at risk of harm, injury, illness and/or death in the event of an emergency if the emergency plan is incomplete, and the residents were unable to be safely evacuated from the facility or community. The findings are: A. Record review of the emergency plan revealed	A 022		

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A 022	Continued From page 24 no documentation of the following information: 1. Evacuation process 2. Persons to be notified 3. Emergency equipment 4. Evacuation routes 5. Refuge areas 6. Responsibilities of personnel during emergencies 7. A list of transportation resources B. On 09/09/19 at 1:50 pm, during an interview, the Administrator confirmed that the Emergency Plans for facility and community wide disasters did not include to above listed information.	A 022		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc;	A 025		

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A 025	Continued From page 25 (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, 01/15/2010]	A 025		

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A 025	Continued From page 26 This REQUIREMENT is not met as evidenced by: 7.8.2.25 B C (2-3) (5) (7) (9) (13) (16-17) E Based on record review and interview the facility failed to ensure for 4 (R #s 1-4) of 4 (R #s 1-4) residents whose Evaluations/Assessments were reviewed for compliance: 1. Were complete and included all the required information. 2. Had been reviewed and/or updated by a licensed practical nurse, registered nurse or physician extender at a minimum of every six months or when a significant change in the residents health status occurs 3. Addressed and included the following areas: a. Cognitive abilities: reasoning and perception, the ability to articulate thoughts, memory function or impairment b. Communication and hearing; ability to communicate needs and understand instructions c. Physical functioning and skeletal problems d. Psychosocial wellbeing e. Activity interest f. Oral and dental status g. Special treatments and procedures or special medical needs such as hospice h. Safety needs/high risk behaviors; history of falls, agitation, wandering, fire safety issues 4. Had been reviewed at the time the Individual Service Plan (ISP) was reviewed This deficient practice has the potential to negatively affect the health and safety of all residents by not receiving needed care and services if the evaluations:	A 025		

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A 025	Continued From page 27 1. Were not complete and included all required information. 2. Had not been reviewed and if needed updated at a minimum of every 6 months or when a change in condition occurred. 3. Did not address and include all required information. 4. Were not reviewed when the ISP was revised. The findings are: A. Record review of R #s 1, 3 and 4 resident files revealed no documentation of any Evaluations/Assessments being completed. B. Record review of R #2's Evaluation/Assessment dated 06/30/18 revealed the following: 1. It had not been reviewed and/or updated by a licensed practical nurse, registered nurse or physician extender at a minimum of every six months or when a significant change in the residents health status occurs. 2. Cognitive abilities: reasoning and perception, the ability to articulate thoughts, memory function or impairment 3. Communication and hearing; ability to communicate needs and understand instructions 4. Physical functioning and skeletal problems 5. Psychosocial wellbeing 6. Activity interest 7. Oral and dental status 8. Special treatments and procedures or special medical needs such as hospice 9. Safety needs / high risk behaviors; history of falls, agitation, wandering, fire safety issues 10. Had not been reviewed at the time the Individual Service Plan is reviewed	A 025		

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(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 025	Continued From page 28 B. On 09/09/19 at 2:00 pm, during an interview, the Administrator confirmed the findings listed above for R #s 1-4 Evaluations/Assessments	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 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	A 026		

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	2165	A. BUILDING: _____ B. WING _____	C 09/09/2019

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A 026	Continued From page 29 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) B (1, 8-9) Based on record review and interview the facility failed to ensure for 4 (R #s 1-4) of 4 (R #s 1-4) residents whose Individual Service Plans (ISP) were reviewed for compliance that they were complete and included all the required information. This deficient practice has the potential to negatively affect the health and safety of residents by not receiving needed care and services if/because care information is not documented on the ISP. The findings are: A. Record review of R #1's resident file revealed no ISP was available for review. B. Record review of R #s 2 & 4 ISPs revealed no documentation of the following: 1. Coordination of care with the hospice provider stating what services facility will provide and what services hospice will provide. 2. A description on needs a noted in resident evaluation due to no evaluation being completed 3. Facility's determination that it is able to meet the resident's needs 4. The level of assistance that the resident will require with activities of daily living	A 026		

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A 026	Continued From page 30 C. Record review of R #3s ISP revealed no documentation of the following: 1. Coordination of care with the hospice provider stating what services facility will provide and what services hospice will provide. 2. A description on needs a noted in resident evaluation due to no evaluation being completed 3. Facility's determination that it is able to meet the resident's needs D. On 09/09/19 at 2:05 pm, during an interview, the Administrator confirmed the findings listed above for R #s 1-4's ISPs.	A 026		
A 027	7 NMAC 8.2.27 Resident Activities RESIDENT ACTIVITIES: Each facility shall provide or make available recreational and social activities appropriate to the residents ' abilities that meet their psychosocial needs and are relevant to their social history; including a balance of cognitive, reminiscence, physical and social activities. The facility shall post the activities and encourage residents to participate. [7.8.2.27 NMAC - Rp, 7.8.2.28 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.27 Based on observation, record review, and interview, the facility failed to provide activities that meet the needs of the residents. This deficient practice has the potential to affect the psychosocial well-being of all 4 (R #s 1-4) residents identified on the census provided by the	A 027		

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A 027	Continued From page 31 Administrator on 09/09/19, through isolation, boredom, and depression. The findings are: A. Record review of the undated Activity Calendar revealed no scheduled activities. A. On 09/05/19 between the hours of 10:50 am and 3:50 pm, no activities were observed taking place. B. On 09/06/19 between the hours of 6:50 am and 2:50 pm, no activities were observed taking place. C. On 09/09/19 between the hours 7:25 am and 3:45 pm no activities were observed taking place. D. On 09/09/19 at 2:15 pm, during an interview, the Administrator confirmed that they did not have any scheduled activities and that no activities took place during the above listed times.	A 027		
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.	A 032		

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A 032	Continued From page 32 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, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation.	A 032		

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A 032	Continued From page 33 B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure that incidents of unusual occurrence (injury of unknown origin) which has or could threaten the health, safety, or welfare of the residents were reported to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend. This deficient practice has the potential for all 4 (R #s 1-4) residents identified on the census provided by the Administrator on 09/09/19 to be at risk of harm, illness, injury if there is no oversight by the Licensing Authority. The findings are: A. Record review of the facility's internal incident report dated 04/02/18 for former resident (R #5) stated that Hospice Staff noticed a bruise of unknown origin on R #5's right shoulder. R #5 needed x rays and was found to have a fractured	A 032		

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A 032	Continued From page 34 shoulder. Facility did not file an incident report with the Licensing Authority until 12/11/18. B. On 09/09/19 at 2:11 pm, during an interview with the Administrator, he confirmed that the above incident for R #5 had not been reported to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend.	A 032		
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	A 033		

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A 033	Continued From page 35	A 033		

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;
(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

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A 033	Continued From page 36 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; (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.	A 033		

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A 033	Continued From page 37 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 (A) Based on record review and interview, the facility failed to ensure that prior to admission the resident and legal representative were given a written description of the legal rights of the resident. This deficient practice has the potential for all 4 (R #s 1-4) residents identified on the census provided by the Administrator on 09/09/19 to be risk for injury or harm due to not understanding what their legal rights are. The findings are: A. Record review of R #s 1- 4 resident files revealed no documentation that the resident/legal representative received information regarding resident rights prior to admission to the facility. B. On 09/09/19 at 2:20 pm during an interview, the Administrator confirmed that written copies of resident rights were not provided to R #s 1-4 or their legal representatives prior to admission to the facility.	A 033		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two	A 034		

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A 034	Continued From page 38 (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 purchase medications from any particular pharmacy.	A 034		

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A 034	Continued From page 39 (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 accurate and current. All irregularities shall be reported to the administrator of the facility and	A 034		

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A 034	Continued From page 40 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: Refer to 7.8.2.34 A (7) and NFPA 99 NFPA 99. 11.3 Cylinder and Container Storage Requirements. 11.3.1* Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of	A 034		

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A 034	Continued From page 41 noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. 11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. 11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour 11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations. 11.3.2.8 Cylinder valve protection caps shall	A 034		

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	2165	A. BUILDING: _____ B. WING _____	C 09/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 034	Continued From page 42 comply with 11.6.2.3. 11.3.2.9 Gas cylinder and liquefied gas container storage shall comply with 5.1.3.5.12. 11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 11.3.3.1 and 11.3.3.2. 11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not be required to be stored in enclosures. 11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. 11.3.3.3 When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders. 11.3.3.4 Individual small-size (A, B, D, or E) cylinders available for immediate use in patient care areas shall not be considered to be in storage. 11.3.3.5 Cylinders shall not be chained to portable or movable apparatus such as beds and oxygen tents. 11.3.4 Signs. 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following wording as a	A 034		

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A 034	Continued From page 43 minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING 2012 Edition Based on observation and interview, the facility failed to ensure that: 1. Oxygen cylinder tanks were stored in a room ventilated to outside air. 2. Oxygen cylinder tanks were secured in a stand, crate, or chain. This deficient practice has the potential for all 4 (R #s 1-4) residents identified on the census provided by the Administrator on 09/09/19, and all occupants of the building, to be at risk of harm, injury, or death in the event of a fire and the oxygen cylinder tanks were knocked over, act like a missile, and/or creates an oxygen rich environment that would accelerate the fire. The findings are: A. On 09/05/19 at 11:36 am, during observation of the oxygen storage room revealed that 3 small oxygen cylinder tanks were observed not secured in a stand, crate, or chain. B. On 09/05/19 at 11:49 am, during observation of the oxygen storage room revealed that the room did not have ventilation to the outside air. C. On 09/09/19 at 3:35 pm, during an interview with Administrator, he confirmed the room where oxygen bottles were stored did not have ventilation to the outside air and that the 3 small tanks were not secured.	A 034		

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A 035	Continued From page 44	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 45 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 46 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 47 (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 B G (2, 4-5, 12) Based on record review and interview, the facility failed to ensure that: 1. All Direct Care Staff (DCS) who assist with medication had completed a state approved assistance with self-administration of medication training program. 2. The Medication Administration Record (MAR) included: a. Both the brand/generic names for medications b. The diagnosis or reason for medication c. All documented allergies to	A 035		

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A 035	Continued From page 48	A 035		

medications
d. The start and end dates of the medications

This deficient practice has the potential for all 4 (R #s 1-4) residents listed on the resident census provided by the Administrator on 09/09/19 to be at risk of harm if medication errors occur because the DCS who assist residents with the self administration of their medications:

1. Have not completed and received a certificate of completion from a state approved Assisting with Self-Administration of medications course.

2. Do not know what the medication (new name) is for, because both the brand and generic names of the medications were not listed on the MAR.

3. Do not know what condition the medication is treating, because the diagnosis or reason for the medication was not listed on the MAR.

4. May not know which medications the residents are allergic to, because the medications that the residents are allergic to were not listed on the MAR.

5. Do not know when a medications is to be started or stopped, if there are no start/end dates for the medications listed on the MAR.

The findings are:

The findings related to medication artificialness

A. Record review of employee files revealed that the Administrator did not have a certificate of completion from a state approved Assisting with the Self Administrator of medications course.

B. Record review of employee files revealed that DCS #4 did not have a certificate of completion

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A 035	Continued From page 49 from a state approved Assisting with the Self Administrator of medications course. C. On 09/09/19 at 2:30 pm, during an interview, the Administrator confirmed that neither he nor DCS #4 had certificates of completion from a state approved Assisting with the Self Administrator of medications course. The findings related the MARs D. Record review of R #1's 09/01/19 through 09/06/19 MAR revealed 12 out of the 12 medications had no documentation of: 1. Both the Brand/Generic names of the medications. 2. The diagnosis or reason for the medications. 3. The start/end dates for the medications. E. Record review of R #2's 09/01/19 through 09/06/19 MAR revealed 16 out of the 16 medications had no documentation of: 1. Both the Brand/Generic names of the medications. 2. The diagnosis or reason for the medications. 3. The start/end dates for the medications. F. Record review of R #3's 09/01/19 through 09/06/19 MAR revealed 16 out of the 16 medications had no documentation of: 1. Both the Brand/Generic names of the medications. 2. The diagnosis or reason for the medications. 3. The start/end dates for the medications. G. Record review of R #3's [redacted]/19 through [redacted]/19 MAR revealed no documentation of the	A 035		

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A 035	Continued From page 50 resident having an allergy to [redacted] which was listed as a current PRN (as needed) medication. H. Record review of R #3's Hospice Certification of Terminal Condition dated 05/02/18 revealed that R # had an allergy to [redacted] I. Record review of R #4's 09/01/19 through 09/06/19 MAR revealed 14 out of the 14 medications had no documentation of: 1. Both the Brand/Generic names of the medications. 2. The diagnosis or reason for the medications. 3. The start/end dates for the medications. J. On 09/09/19 at 2:30 pm, during an interview, the Administrator confirmed the missing and incorrect information listed above for R #s 1-4 MARs.	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 infectious and communicable disease.	A 037		

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A 037	Continued From page 51 (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 (10)	A 037		

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A 037	Continued From page 52 Based on observation and interview, the facility failed to ensure that the cleaning supplies/chemicals were stored in secure areas and not accessible to residents. This deficient practice has the potential for all 4 (R #s 1-4) residents identified on the census provided by the Administrator on 09/09/19, to be at risk of harm, injury, or death if residents were to ingest or spill cleaning supplies/chemicals on their face or body. The findings are: A. On 09/05/19 at 11:53 am, during observation of the first-floor laundry room, the following cleaning supplies/chemicals were observed to be stored in an unlocked laundry room and accessible to all residents: 1. (1) bottle of Furniture Oil Soap 2. (1) bottle of liquid drain cleaner 3. (1) bottle of floor polish 4. (1) can of disinfectant 5. (1) bottle of bathroom concentrate cleaner 7. (3) bottles of ant bait 8. (3) packages of ant bait 9. (1) can of glass cleaner 10. (1) bottle of cleaner with bleach 11. (1) bottle of window cleaner 12. (2) cans of cleaner 13. (4) cans of furniture polish 14. (1) can of spray disinfectant 15. (2) jugs of pesticides 16. (3) jugs of bleach B. On 09/05/19 at 3:30 pm, during an interview, the Administrator confirmed that the above listed cleaning supplies/chemicals were stored unsecured in the laundry room and accessible to residents.	A 037		

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A 045	Continued From page 53	A 045		
A 045	7 NMAC 8.2.45 Water WATER: Pursuant to the current New Mexico drinking water requirements, 7.6.2.9 NMAC. A. The water supply system shall be constructed, protected, operated and maintained in conformance with applicable local, state and federal laws, ordinances and regulations. B. Where a facility is supplied by its own water system, the system shall meet the sampling and construction requirement of a non-community water system as defined by the current New Mexico drinking water requirements. C. All water that is not piped into the facility directly from a public water supply system shall be from an approved source, disinfected, transported, handled, stored and dispensed in a sanitary manner. Such water shall be prevented from entering potable water systems by appropriate cross connection and backflow prevention devices. D. Hot and cold running water, under pressure shall be provided in all areas where food is prepared and where equipment and utensils are washed, sinks, lavatories, washrooms and laundries. E. The hot water temperature that is accessible to residents shall be maintained at a minimum of ninety-five (95) degrees fahrenheit and a maximum of one hundred ten (110) degrees fahrenheit. Hot water in excess of one hundred ten (110) degrees fahrenheit is permitted in kitchen and laundry areas, provided that residents are supervised in order to prevent injury. [7.8.2.45 NMAC - Rp, 7.8.2.46 NMAC, 01/15/2010]	A 045		

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A 045	Continued From page 54 This REQUIREMENT is not met as evidenced by: 7.8.2.45 E Based on observation and interview, the facility failed to maintain the hot water at a maximum temperature of 110 degrees Fahrenheit (F). This deficient practice has the potential for all 4 (R #s 1-4) residents on the census list provided by the Administrator on 09/09/19, to be at risk of harm/injury if they are scalded by water that is too hot. The findings are: A. On 09/09/19 at 12:00 pm, during observation and tour of the facility, the hot water temperature in the kitchen sink which is accessible to residents was 117 degrees F. B. On 09/09/19 at 12:00 pm, during an interview, the Administrator confirmed that the hot water temperature in the kitchen sink accessible to residents was 117 degrees F.	A 045		
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	A 049		

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(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 049	Continued From page 55 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 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 A (1) Based on observation and interview, the facility failed to ensure that the locks on the 2 emergency exit doors (not connected to a fire	A 049		

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	2165	A. BUILDING: _____ B. WING _____	C 09/09/2019

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A 049	Continued From page 56 detection/sprinkler systems or the power) could be operated by all residents/occupants. This deficient practice has the potential for all 4 (R #s 1-4) residents identified on the census provided by the Administrator on 09/09/19, to be at risk of harm, injury, or death if a fire or other emergency requiring evacuation occurred and residents/occupants were are unable to exit the facility. The findings are: A. On 09/05/19 at 11:16 am, during observation of the front exit door, it was observed the door was locked, had a both a dead bolt and turn knob lock that could not be unlocked by all residents and occupants of the facility. B. On 09/05/19 at 11:18 am, during observation of the back exit door, it was observed that the door had both a dead bolt and turn knob locks, that could not be unlocked by all residents and occupants of the facility. C. On 09/05/19 at 3:15 pm, during an interview, the Administrator, confirmed that the emergency exit doors had both dead bolt and turn knob locks, that could not be unlocked by all residents and occupants of the facility.	A 049		
A 055	7 NMAC 8.2.55 Toilet and Bathing Facilites TOILET AND BATHING FACILITIES: Toilet and bathing facilities shall be located appropriately to meet the needs of residents. A. A minimum of one (1) toilet, one (1) sink and one (1) bathing unit shall be provided for every eight (8) residents or fraction there of.	A 055		

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A 055	Continued From page 57 (1) The facility shall provide at least one tub and one shower or combination unit to allow for residents bathing preference. (2) Facilities with four (4) or more residents shall provide a handicap accessible bathroom for every thirty (30) residents that allows for a bathing preference. B. Facilities with four (4) or more residents must comply with accessibility requirements for the disabled. C. Toilet, sink and bathing facilities shall be readily available to the residents. No passage through a resident room by another resident to reach a toilet, bathing unit or sink facility shall be permitted. D. The combination type tub and shower shall be permitted. E. A facility with four (4) or more residents that has live-in staff shall provide a separate toilet, sink and bathing facility for staff. F. Toilets, tubs and showers shall be provided with grab bars. G. Tubs and showers shall have a slip resistant surface. H. The floors of bathrooms and bathing facilities shall have smooth, waterproof and slip-resistant surfaces. I. Toilet paper and soap shall be provided in each toilet room. J. The use of a common towel shall be prohibited. K. Bathrooms and lavatories shall be cleaned as often as necessary to maintain a clean and sanitary condition. [7.8.2.55 NMAC - Rp, 7.8.2.56 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.55 A (1)	A 055		

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A 055	Continued From page 58 Based on observation and interview the facility failed to ensure that the only bathtub located in bathroom #3 was: 1. In good working condition so that resident's could use it for bathing. 2. Was not being use for storage of durable medical equipment (DME). This deficit practice has the potential for all 4 (R #s 1-4) residents identified on the census provided by the Administrator on 09/09/19, not to have a choice of a bathing preferences. The finding are: A. On 09/05/19 at 11:39 am, during an observation of the bathtub located in bathroom #3 was observed being used for storage and was filled with unused durable medical equipment (DME) covered with a shower curtain and not available for use by the residents. B. On 09/05/19 at 3:40 pm, during an interview, the Administrator confirmed that the bathtub was being used for storage of unused DME and not available for use by the residents.	A 055		
A 060	7 NMAC 8.2.60 Fire Clearence and Inspections FIRE CLEARANCE AND INSPECTIONS: A. Written documentation of a facility's compliance with applicable fire prevention codes shall be obtained from the state fire marshal ' s office or the fire prevention authority with jurisdiction and shall be submitted to the licensing authority prior to the issuance of an initial license. B. The facility shall request an annual fire inspection from the local fire prevention authorities. If the policy of the local fire	A 060		

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A 060	Continued From page 59 department does not provide an annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility. [7.8.2.60 NMAC - Rp, 7.8.2.59 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.60 B Based on record review and interview, the facility failed to ensure that an annual fire inspection by the local Fire Authority (having jurisdiction) had been conducted. This deficient practice has the potential for all 4 (R #s 1-4) residents identified on the resident census list provided by the Administrator on 09/09/19, to be at risk of injury or death if a fire occurs. The findings are: A. Record review of the annual fire inspection reports revealed that there had not been an annual fire inspection since 11/06/17. B. On 09/09/19 at 2:45 pm, during an interview, the Administrator confirmed that there had not been an annual fire inspection done since 11/06/17.	A 060		
A 061	7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: A. Fire alarm system. Facilities with four (4) or	A 061		

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A 061	Continued From page 60 more residents shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction. B. Smoke and heat detection. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining and living room(s) must also be provided with smoke detectors. (1) Detectors shall be powered by the house electrical service and have battery back up. (2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room. (3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service. [7.8.2.61 NMAC - Rp, 7.8.2.60 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.61 B Based on observation and interview, the facility failed to ensure that all smoke detectors were in working order. This deficient practice has the potential for all 4 (R #s 1-4) residents listed on the census provided by the Administrator on 09/09/19, and all occupants of the building to be at risk of harm, injury, or death if the smoke alarms did not sound a warning to the residents/occupants that there was a fire and to evacuate. The findings are:	A 061		

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A 061	Continued From page 61 A. On 09/09/19 at 10:10 am, during observation and tour of the facility, the smoke detectors in 2 unoccupied resident rooms were observed to not be working, one was clearly missing a battery. B. On 9/09/2019 at 10:30 am. during an interview with the Administrator, he confirmed that the smoke detectors in the 2 unoccupied resident rooms were not in working order.	A 061		
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	A 063		

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A 063	Continued From page 62 Based on observation and interview, the facility failed to ensure the fire extinguishers had been inspected monthly and annually to ensure proper working order. This deficient practice has the potential for all 4 (R #s 1-4) residents identified on the census provided by the Administrator on 09/09/19 to be at risk of injury or death if there was a fire and the fire extinguishers did not work properly. The findings are: A. On 09/05/19 at 11:46 am, during observation and tour of the facility, it was observed that 2 of 2 fire extinguishers have not had monthly inspections since 07/01/19. B. On 09/05/19 at 11:46 am, during observation and tour of the facility, it was observed that 2 of 2 fire extinguishers had not had an annual inspection since August 2018. C. On 09/05/19 at 3:32 pm, during an interview, the Administrator confirmed that the facility's 2 fire extinguishers had not been: 1. Inspected monthly since 07/01/19. 2. Inspected annually since August 2018.	A 063		
A 064	7 NMAC 8.2.64 Fire Safety Equivalency System Rating FIRE SAFETY EQUIVALENCY SYSTEM RATING: In facilities without a sprinkler system; the fire safety equivalency system shall be conducted at least annually. The facility shall maintain an evacuation rating score of prompt when a fire safety equivalency system is required. [7.8.2.64 NMAC - Rp, 7.8.2.19 NMAC, 01/15/2010]	A 064		

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A 064	Continued From page 63 This REQUIREMENT is not met as evidenced by: 7.8.2.64 Based on record review and interview, the facility failed to ensure that a the Fire Safety Equivalency System Rating (FSES) score forms were completed at least annually and available for review. This deficient practice has the potential for all 4 (R #s 1-4) residents identified on the census, by the Administrator on 09/09/19 to be at risk of harm, injury, or death if there are not enough staff on duty to safely evacuate the residents if a fire were to occur. The findings are: A. Record request for the facility's Fire Safety Equivalency Score (FSES) forms, revealed there were no forms available to review. B. On 09/09/19 at 2:41 pm, during an interview with Administrator, he confirmed that there were no FSES forms available for review, because the facility had never completed them.	A 064		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill;	A 065		

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A 065	Continued From page 64 (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 A Based on record review and interview, the facility failed to ensure that a fire drill was conducted and documented monthly on each 8-hour shift (morning, afternoon, graveyard) per quarter. This deficient practice has the potential for 4 (R #s 1-4) residents identified on the census, provided the Administrator on 09/09/19, to be at risk of harm, injury, or death if staff and residents are aware of how to safely evacuate the building in case of a fire. The findings are: A. Record request for documentation of the monthly fire drill records revealed documentation that the last three facility fire drills were conducted on 04/01/19 at 6:30 am, 03/05/19 at 6:30 pm, and 12/03/18 at 10:00 am. B. On 09/09/19 at 2:45 pm, during an interview, the Administrator confirmed that monthly fire drills were not being conducted with 1 drill on each 8-hour (morning, afternoon, and graveyard) shift per quarter.	A 065		

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A 068	Continued From page 65	A 068		
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. (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	A 068		

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A 068	Continued From page 66 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 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;	A 068		

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A 068	Continued From page 67 (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); (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	A 068		

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A 068	Continued From page 68 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 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.	A 068		

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	2165	A. BUILDING: _____ B. WING _____	C 09/09/2019

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A 068	Continued From page 69 (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 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 B (1) Based on record review and interview, the facility failed to ensure that Direct Care Staff (DCS) had the required six (6) hours of palliative/hospice	A 068		

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A 068	Continued From page 70 training including one hour specific to resident's Individual Service Plan (ISP) annually when the facility is providing care and services for hospice residents. This deficient practice has the potential for all 4 (R #s 1-4,) residents identified as receiving hospice services by the Administrator 09/09/19, to be at risk of harm or injury if DCS do not know the proper methods of providing care and services. The findings are: A. Record review of DCS #1's employee file (date of hire 05/16/13) revealed no documented of 6 hours of Palliative/Hospice care training in the past year. B. Record review of DCS #2's employee file (date of hire 07/19/16) revealed no documented of 6 hours of Palliative/Hospice care training in the past year. C. Record review of DCS #3's employee file (date of hire 12/09/09) revealed no documented of 6 hours of Palliative/Hospice care training in the past year. D. On 09/09/19 at 2:45 pm, during an interview, the Administrator confirmed that DCS #s 1-3 had not received the required 6 hours of palliative/hospice care training in the past year.	A 068		
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,	A 069		

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A 069	Continued From page 71 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 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	A 069		

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A 069	Continued From page 72 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 " 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.	A 069		

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A 069	Continued From page 73 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 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	A 069		

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A 069	Continued From page 74 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 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.	A 069		

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A 069	Continued From page 75 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 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 the Direct Care Staff (DCS) received twelve (12) hours of Dementia/Alzheimer's training annually. This deficient practice has the potential for the 3 (R #s 2-4) residents diagnosed with dementia, to be at risk of not receiving the individual (physical, mental, social) care and services residents with Dementia require, because the DCS have not completed the required annual specialized Dementia/Alzheimer's training. The finding are. A. Record review of DCS #s 1-3 staff files	A 069		

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A 069	Continued From page 76 revealed no documentation that they received/completed the required twelve (12) hours of Dementia/Alzheimer's training annually. B. On 09/09/19 at 2:47 pm, during interview, the Administrator confirmed that DCS #s 1-3 had not received/completed the required twelve (12) hours of Dementia/Alzheimer's training annually.	A 069		