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| A 000 | Initial Comments<br><br>The following deficiencies were cited during a Full-Onsite/Complaint survey completed on 08/15/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.<br><br>Complaint Intake NM#30619 was substantiated with deficiencies cited.<br>Complaint Intake NM#38227 was unsubstantiated with no deficiencies cited. | A 000 | | |
| A 016 | 7 NMAC 8.2.16 Staff Qualifications<br><br>STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications.<br>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:<br>(1) be at least twenty-one (21) years of age;<br>(2) have a high school diploma or its equivalent;<br>(3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC;<br>(4) complete a state approved certification program for assisted living administrators;<br>(5) be able to communicate with the residents in the language spoken by the majority of the residents;<br>(6) not work while under the influence of alcohol or illegal drugs;<br>(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;<br>(8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and<br>(9) comply with the pre-employment requirements | A 016 | | |

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| A 016 | Continued From page 1<br>pursuant to the Employee Abuse Registry, 7.1.12 NMAC.<br>B. Direct care staff:<br>(1) shall be at least eighteen (18) years of age;<br>(2) shall have adequate education, relevant training, or experience to provide for the needs of the residents;<br>(3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and<br>(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;<br>(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:<br>(a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents;<br>(b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation;<br>(c) proof of insurance; and<br>(d) documentation of a clean driving record;<br>(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<br>(7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC.<br>[7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, | A 016 | | |

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| A 016 | Continued From page 2<br>01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.16 B (3) (7)<br><br>7.1.12 EMPLOYEE ABUSE REGISTRY<br><br>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.<br>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.<br>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.<br>C. Applicant's identifying information required. In | A 016 | | |

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| A 016 | Continued From page 3 | A 016 | | |

making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social 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

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| A 016 | Continued From page 4 | A 016 | | |

directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.
[7.1.12.8 NMAC - N, 01/01/2006]

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

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| A 016 | Continued From page 5<br>rules. The fees will not be applied to any other activity or expense undertaken by the Department.<br>. . .<br><br>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.<br>The fees will not be applied to any other activity or expense undertaken by the department.<br>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 | A 016 | | |

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| A 016 | Continued From page 6<br>the care provider.<br>G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules.<br>(1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification.<br>(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.<br><br>Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS):<br>1. Were cleared by the Employee Abuse Registry (EAR) prior to hire.<br>2. Fingerprints and application were submitted to Criminal History Screening Program (CCHSP) within 20-days after hire.<br><br>This deficient practice has the potential for all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 08/12/19 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. | A 016 | | |

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| A 016 | Continued From page 7<br><br>The findings are:<br><br>A. Record review of DCS #1's employee file (hire date 06/25/18) revealed that the EAR/CCHSP were not submitted until of 08/14/19.<br><br>B. Record Review of DCS #2's employee file (hire date 06/17/18) revealed that the EAR/CCHSP were not submitted until 08/12/19.<br><br>C. Record review of DCS #3's employee file (hire date 10/26/18) revealed that the EAR/CCHSP were not submitted until 08/15/19.<br><br>D. On 08/15/19 at 1:30 pm, during an interview, the Administrator confirmed for DCS #s 1-3 that their:<br>1. EAR clearances were not received prior to hire.<br>2. Fingerprints and applications were not submitted to the CCHSP within 20-day after hire. | A 016 | | |
| A 018 | 7 NMAC 8.2.18 Policies<br><br>POLICIES: The facility shall have and implement written personnel policies for the following:<br>A. staff, private duty attendant and volunteer qualifications;<br>B. staff, private duty attendant and volunteer conduct;<br>C. staff, private duty attendant and volunteer training policies;<br>D. staff and private duty attendant and volunteer criminal history screening;<br>E. emergency procedures;<br>F. medication administration;<br>G. the retention and maintenance of current and past personnel records; and | A 018 | | |

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| A 018 | Continued From page 8<br>H. facilities shall maintain records and files that reflect compliance with NM and federal employment rules.<br>[7.8.2.18 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.18 A C G<br><br>Based on record review and interview, the facility failed to have all the required written personnel policies for staff and volunteers.<br><br>This deficient practice has the potential for all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 08/12/19, to be at risk of harm or injury if staff are not trained or aware of the correct way to implement facility policy and procedures that affect the safety and welfare of the residents. The findings are:<br><br>A. Record review of the facility's Policy and Procedure Manual revealed that the following required personnel policies were missing:<br>1. Staff, private duty attendant, and volunteer qualifications.<br>2. Staff, private duty attendant, and volunteer training policies.<br>3. The retention and maintenance of current and past personnel records.<br><br>B. On 08/15/19 at 1:50 pm, during an interview, the Administrator confirmed that there were no written facility personnel policies for the findings listed above. | A 018 | | |

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| A 019 | Continued From page 9 | A 019 | | |
| A 019 | 7 NMAC 8.2.19 Staffing Ratios<br><br>STAFFING RATIOS: The following staffing levels are the minimum requirements.<br>A. The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents ' needs.<br>(1) During resident waking hours, facilities shall have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents.<br>(2) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty, awake and responsible for the care and supervision of the residents.<br>(3) During resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises.<br>(4) During resident sleeping hours, facilities with thirty-one (31) to sixty (60) residents shall have at least two (2) direct care staff persons on duty and awake at all times and at least one (1) additional staff person immediately available on the premises.<br>(5) During resident sleeping hours, facilities with more than sixty-one (61) residents shall have at least three (3) direct care staff persons on duty and awake at all times and one (1) additional staff person immediately available on the premises for each additional thirty (30) residents or fraction thereof in the facility.<br>B. Upon request of the department, the facility shall provide the staffing ratios per each twenty-four (24) hour day for the past thirty (30) days. | A 019 | | |

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| A 019 | Continued From page 10<br>[7.8.2.19 NMAC - Rp, 7.8.2.18 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.19 A (3)<br><br>Based on record review, and interview, the facility failed to provide the minimum staffing ratio of one awake staff and one additional staff immediately available on the premises, required during the resident sleeping hours.<br><br>This deficient practice has the potential to put all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 08/12/19, to be at risk of harm or death if there is not enough Direct Care Staff (DCS) to provide safe, efficient care during this shift.<br><br>The findings are:<br><br>A. Record review of employee schedules and times sheets provided by the Administrator of 08/15/19, revealed no evidence of 2 staff working in Memory Care on the following dates: 07/16/19 through 07/25/19, 07/27/19 through 08/01/19, and 08/06/19 through 08/14/19.<br><br>B. On 08/13/19, at 6:07 pm, during an interview, DCS # 5 confirmed only one staff was on duty in Memory Care at night.<br><br>C. On 08/15/19, at 7:05 am, during an interview, DCS #3 confirmed only one staff was on duty in Memory Care the previous night.<br><br>D. On 08/15/19, at 7:15 am, during an interview, DCS #1 confirmed only one staff was on duty in | A 019 | | |

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| A 019 | Continued From page 11<br>Memory Care the previous night.<br><br>E. On 08/15/19 at 1:15 pm, during an interview, the Administrator refused to confirm only one staff was on duty in Memory Care at night. | A 019 | | |
| A 020 | 7 NMAC 8.2.20 Admissions and Discharge<br><br>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.<br>A. Admission agreement. The admission agreement shall include the following information:<br>(1) the parties to the agreement;<br>(2) the program narrative;<br>(3) the facility's rules;<br>(4) the cost of services and the method of payment;<br>(5) the refund provision in case of death, transfer, voluntary or involuntary discharge;<br>(6) information to formulate advance directives;<br>(7) a written description of the legal rights of the residents translated into another language, if necessary;<br>(8) the facility's staffing ratio;<br>(9) written authorization for staff to assist with medications;<br>(10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC;<br>(11) the facility ' s bed hold policy; and<br>(12) the admission agreement may be terminated | A 020 | | |

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| A 020 | Continued From page 12<br>if an appropriate placement is found for the resident, under the following circumstances:<br>(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;<br>(b) the resident has failed to pay for a stay at the facility as defined in the admission agreement;<br>(c) the facility ceases to operate or is no longer able to provide services to the resident;<br>(d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility;<br>(e) termination without prior notice is permitted in emergency situations for the following reasons:<br>(i) the transfer or discharge is necessary for the resident's safety and welfare;<br>(ii) the resident's needs cannot safely be met in the facility; or<br>(iii) the safety and health of other residents and staff in the facility are endangered;<br>(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<br>(14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents.<br>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: | A 020 | | |

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| A 020 | Continued From page 13<br>(1) ventilator dependency;<br>(2) pressure sores and decubitus ulcers (stage III or IV);<br>(3) intravenous therapy or injections;<br>(4) any condition requiring either physical or chemical restraints;<br>(5) nasogastric tubes;<br>(6) tracheostomy care;<br>(7) residents that present an imminent physical threat or danger to self or others;<br>(8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP;<br>(9) residents with a diagnosis that requires isolation techniques;<br>(10) residents that require the use of a Hoyer lift; and<br>(11) ostomy (unless resident is able to provide self care).<br>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.<br>(1) Convene a team, comprised of:<br>(a) the facility administrator and a facility health care professional if desired;<br>(b) the resident or resident ' s surrogate decision maker; and<br>(c) the hospice or home health clinician.<br>(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 | A 020 | | |

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| A 020 | Continued From page 14<br>resident's record and shall:<br>(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;<br>(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);<br>(c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and<br>(d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility.<br>(3) The team recommendation shall be maintained on site in the resident ' s file.<br>(4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident.<br>D. Coordination of care.<br>(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.<br>(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.<br>[7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] | A 020 | | |

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| A 020 | Continued From page 15<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.20 A (5) (10) (13)<br><br>Refer to Senate Bill (SB) 0335 - 2013<br><br>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:<br><br>SECTION 1. A new section of the Public Health Act is enacted to read:<br>"ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.--<br>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.<br>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 | A 020 | | |

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| A 020 | Continued From page 16 | A 020 | | |

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

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

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

Based on record review and interview the facility failed to ensure 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. 30-day written notice of change in the cost or the material services provided.
3. Rights and responsibilities regarding incident reporting

These deficient practices have the potential for all 16 (R #1-16) residents identified on the census given by the Administrator on 08/12/19, 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 additional charges that may be owed.
2. Cost or material services provided are

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| A 020 | Continued From page 17<br>changed without the proper written notice being given to the resident/surrogate decision maker.<br>3. Residents or Power of Attorney's (POA's) do not understand their rights and responsibilities regarding the reporting of suspected abuse, neglect or exploitation.<br><br>The findings are:<br><br>A. Record review of R #'s 1-4 Admission/Discharge Agreements revealed, the following missing information:<br>1. Refund provision in case of death that is in compliance with 7.8.2.20 and Senate Bill (SB) 0335 - 2013.<br>2. 30-day written notice in the event of change of cost or material services provided given to the resident/surrogate decision maker.<br>3. Rights and responsibilities regarding incident reporting.<br><br>B. On 08/15/19 at 2:00 pm, during an interview, the Administrator confirmed that above listed findings were missing from R #s 1-4 Admission/Discharged Agreements. | A 020 | | |
| A 022 | 7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies<br><br>FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES:<br>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:<br>(1) fire inspection report;<br>(2) zoning approval; | A 022 | | |

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| A 022 | Continued From page 18<br>(3) building official approval (certificate of occupancy);<br>(4) a copy of the approved building plans;<br>(5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints;<br>(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 requirements by the local health authority, a copy of that determination must also be maintained;<br>(7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction;<br>(8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks;<br>(9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSES) rating, if applicable;<br>(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:<br>(a) an emergency that affects just the facility; and | A 022 | | |

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| A 022 | Continued From page 19<br>(b) a region/area wide emergency;<br>(11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC);<br>(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<br>(13) vaccination records for pets in the facility.<br>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:<br>(1) a copy of the facility license;<br>(2) employee personnel records, including an application for employment, training records and personnel actions:<br>(a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC;<br>(b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and<br>(3) a copy of all waivers or variances granted by the licensing authority.<br>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:<br>(1) resident use of tobacco and alcohol;<br>(2) resident use of facility telephone or personal cell phone;<br>(3) resident use of television, radio, stereo and cd;<br>(4) the use and safekeeping of residents ' personal property;<br>(5) meal availability and times;<br>(6) resident use of common areas; | A 022 | | |

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| A 022 | Continued From page 20<br>(7) accommodation of resident ' s pets; and<br>(8) resident use of electric blankets and appliances.<br>D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas:<br>(1) actions to be taken in case of accidents or emergencies;<br>(2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six<br>(6) months or when a significant change occurs, such as a hospital admission;<br>(3) policy for medication errors;<br>(4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.);<br>(5) the handling of resident's funds, if the facility provides such services;<br>(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;<br>(7) reporting and investigating internal complaints;<br>(8) reporting and investigating complaints to the incident management bureau;<br>(9) staff and resident fire and safety training;<br>(10) smoking policy for staff, residents and visitors;<br>(11) the facility's bed hold policy;<br>(12) admission agreement;<br>(13) admission records;<br>(14) resident records including maintenance and record retention if the facility closes;<br>(15) program narrative;<br>(16) resident's rights with regard to making health | A 022 | | |

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| A 022 | Continued From page 21<br>care decisions and the formulation of advance directives;<br>(17) personnel policies;<br>(18) identifying and safeguarding resident possessions;<br>(19) securing medical assistance if a resident's own physician is not available;<br>(20) staff training appropriate to staff responsibilities;<br>(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;<br>(22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and<br>(23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting.<br>[7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.22 A (8) (10) (a-b)<br><br>Based on record review and interview the facility failed to ensure that there were:<br>1. Records of 30 days of menus as served including snacks.<br>2. Written emergency evacuation plans for emergencies that affects just the facility and a community wide disaster to include transportation resources and refuge area.<br><br>These deficient practices have the potential for all | A 022 | | |

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| A 022 | Continued From page 22<br>16 (R #s 1-16) residents listed on the census provided by the Administrator 08/12/19, to be at risk of harm, injury, illness and/or death if there was no:<br>1. History of meals served to evaluate for adequate nutrition is not documented.<br>2. Evacuation plan if a disaster occurred, and the residents were unable to be safely evacuated from the facility or community.<br><br>The findings are:<br><br>A. Record request for 30 days of menus as served including snacks revealed the facility had no documentation of the menus.<br><br>B. Record request for the emergency evacuation plan for facility disasters revealed no documentation that the facility had a plan in place.<br><br>C. Record request for the emergency evacuation plan for community-wide disasters revealed no documentation that the facility had a plan in place.<br><br>D. On 08/14/19 at 9:50 am, during an interview, the Cook confirmed that the facility does not have a record of 30 days of menus as served.<br><br>E. On 08/15/19 at 2:10 pm, during an interview, the Administrator confirmed that the facility does not have:<br>1. 30 days of menus as served.<br>2. Emergency evacuation plans for disasters or emergencies that affect either the facility or the community to include transportation resources and refuge areas. | A 022 | | |

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| A 025 | Continued From page 23 | A 025 | | |
| A 025 | 7 NMAC 8.2.25 Resident Evaluation<br><br>RESIDENT EVALUATION:<br>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.<br>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.<br>C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status:<br>(1) activities of daily living;<br>(2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc;<br>(3) communication and hearing; ability to communicate needs and understand instructions, etc;<br>(4) vision;<br>(5) physical functioning and skeletal problems;<br>(6) incontinence of bowel/bladder;<br>(7) psychosocial well-being;<br>(8) mood and behavior;<br>(9) activity interests;<br>(10) diagnoses;<br>(11) health conditions;<br>(12) nutritional status;<br>(13) oral or dental status;<br>(14) skin conditions;<br>(15) medication use and level of assistance | A 025 | | |

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| A 025 | Continued From page 24<br>needed with medications;<br>(16) special treatments and procedures or special medical needs such as hospice; and<br>(17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc.<br>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.<br>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.<br>[7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.25 B<br><br>Based on record review and interview the facility failed to ensure for 3 (R #s 1-3) of 4 (R #s 1-4) residents whose Evaluations were reviewed for compliance that they were reviewed and/or updated at a minimum of every 6 months. This deficient practice has the potential to negatively affect the health and safety of residents by not receiving needed care/services if the Direct Care Staff (DCS) do not know what resident's needs are. The findings are:<br><br>Record review of R #1's Evaluation dated | A 025 | | |

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| A 025 | Continued From page 25<br>01/13/19 revealed it had not been updated at a minimum of every 6 months was available for review.<br><br>B. Record review of R #2's Evaluation dated 04/04/18 revealed it had not been updated at a minimum of every 6 months was available for review.<br><br>C. Record review of R #3's Evaluation dated 03/30/18 revealed it had not been updated at a minimum of every 6 months was available for review<br><br>D. On 08/13/19, at 10:05 am, during an interview with the Administrator, she stated that she had updated Evaluations for R # 2 & 3 in the computer and that she would provide them for review.<br><br>E. On 08/15/19 at 3:15 pm, during the exit interview with the Administrator, she confirmed that the updated evaluations for R #s 2 & 3 were not provided for review prior to exit. | A 025 | | |
| A 026 | 7 NMAC 8.2.26 Individual Service Plan<br><br>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.<br>A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation.<br>(1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies.<br>(2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed | A 026 | | |

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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 medications;
(10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and
(11) current orders for all medications, including those authorized for PRN usage.
[7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.26 A (1) (3)

Based on record review and interview, the facility failed to ensure for 2 (R #s 2-3) of 4 (R #s 1-4) residents whose Individual Service Plans (ISP) were reviewed for compliance that they were:
1. Reviewed and/or updated at a minimum of

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every 6 months.
2. Included coordination of care coordination between Hospice and the facility.

These deficient practices have the potential to negatively affect the health and safety of residents by not receiving needed care/services needed if the:
1. ISPs have not been updated and the Direct Care Staff (DCS) are not providing the correct care or services.
2. DCS do not know what care/services they need to provide and what care/services hospice with provided.

The findings are:

A. Record Review of R #1's ISP dated 01/13/19 revealed no documentation of an ISP updated within the past 6 months was available for review.

B. Record review of R #2's ISP dated 04/09/18 revealed no documentation of an ISP updated within the past 6 months was available for review.

C. Record review of R #3's ISP dated 04/04/18 revealed no documentation of:
1. An ISP updated within the past 6 months was available for review.
2. Coordination of care with Hospice.

D. On 08/13/19, at 10:05 am, during an interview with the Administrator she stated that the updated ISPs were in the computer and would provide them for review.

E. On 08/15/19 at 3:15 pm, during the exit interview with the Administrator, she confirmed that the updated ISPs for #s 2 & 3 were not provided for review prior to exit.

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| A 033 | 7 NMAC 8.2.33 Resident Rights<br><br>RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents.<br>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.<br>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:<br>(1) the resident's spouse;<br>(2) significant other;<br>(3) any of the resident's adult children;<br>(4) the resident's parents;<br>(5) any relative the resident has lived with for six or more months before admission;<br>(6) a person who has been caring for, or paying benefits on behalf of the resident;<br>(7) a placing agency;<br>(8) resident advocate; or<br>(9) the ombudsman.<br>C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program.<br>D. To protect resident rights, the facility shall:<br>(1) treat all residents with courtesy, respect, dignity and compassion;<br>(2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality;<br>(3) provide residents written information about all services provided by the facility and their costs | A 033 | | |

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and give advance written notice of any changes;
(4) provide residents with a safe and sanitary living environment;
(5) provide humane care for all residents;
(6) provide the right to privacy, including privacy during medical examinations, consultations and treatment;
(7) protect the confidentiality of the resident ' s medical record;
(8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room;
(9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations;
(10) prohibit the use of any and all physical and chemical restraints;
(11) ensure that residents:
(a) are free from physical and emotional abuse neglect and misappropriation/or exploitation;
(b) are free from financial abuse and misappropriation by facility staff or management;
(c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility;
(d) are free to leave the facility and return without unreasonable restriction;
(e) are given a fifteen (15) calendar day, written 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

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| A 033 | Continued From page 30<br>by the facility;<br>(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;<br>(i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner;<br>(j) have the right to participate in the development of their care plan/ISP;<br>(k) have the right to choose a doctor, pharmacist and other health care provider(s);<br>(l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney;<br>(m) have the right to keep and use personal possessions without loss or damage;<br>(n) have the right to manage and control their personal finances;<br>(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;<br>(p) shall not be required to work for the facility; and<br>(q) are protected from unjustified room transfers or discharge.<br>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]<br><br>This REQUIREMENT is not met as evidenced by: | A 033 | | |

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| A 033 | Continued From page 31<br>7.8.2.33 D (10) (11) (a)<br><br>Based on observation, record review, and interview, the facility failed to ensure that:<br>1. Residents are free from physical restraint<br>2. Free from punishment and abuse.<br><br>This deficient practice has the potential for all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 08/12/19 to be risk for injury or harm due to:<br>1. Residents being unable to get up or move due to the use of restraints<br>2. Residents being unable to have access to belongings due to things being taken away as punishment.<br><br>The findings are:<br>Findings related to restraints<br><br>A. On 08/13/19 at 11:47 am, during observation R #s 7 and 8 were observed in Geri chairs (recliner on wheels) with trays attached being used as restraints and preventing freedom of movement.<br><br>B. On 08/13/19, at 4:50 pm, during a interview with the Administrator, she confirmed that [redacted]<br><br>Findings related to cigarette privileges<br><br>C. Record review of R #2's incident reports and communication notes revealed, that on 06/29/19, 07/25/19, 08/07/19, 08/12/19 cigarette privileges were withheld as punishment due to behaviors.<br><br>D. On 08/15/19 at 11:44 am, during an interview, the Administrator confirmed that R #2's cigarettes were being withheld as punishment due to | A 033 | | |

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| A 033 | Continued From page 32<br>behaviors. | A 033 | | |
| A 034 | 7 NMAC 8.2.34 Custodial Drug Permits<br><br>CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy.<br>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.<br>(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.<br>(2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms.<br>(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.<br>(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.<br>(5) A resident may be permitted to keep his or her own medication in a locked compartment in his or | A 034 | | |

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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.
(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.

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| A 034 | Continued From page 34<br>(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 these irregularities shall be resolved by the administrator within seventy-two (72) hours.<br>(2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation.<br>(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.<br>(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.<br>[7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.34 A. (4) (7)<br>NFPA 99.<br>11.3 Cylinder and Container Storage Requirements.<br>11.3.1* Storage for nonflammable gases equal to or greater than<br>85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3.<br>11.3.2* Storage for nonflammable gases greater than 8.5 m3<br>(300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply<br>with the requirements in 11.3.2.1 through | A 034 | | |

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| A 034 | Continued From page 35<br>11.3.2.3.<br>11.3.2.1 Storage locations shall be outdoors in an enclosure or<br>within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.<br>11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide,<br>shall not be stored with any flammable gas, liquid, or vapor.<br>11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide<br>shall be separated from combustibles or materials by one of<br>the following:<br>(1) Minimum distance of 6.1 m (20 ft)<br>(2) Minimum distance of 1.5 m (5 ft) if the entire storage<br>location is protected by an automatic sprinkler system designed<br>in accordance with NFPA 13, Standard for the Installation<br>of Sprinkler Systems<br>(3) Enclosed cabinet of noncombustible construction having<br>a minimum fire protection rating of 1?2 hour<br>11.3.2.4 Gas cylinder and cryogenic liquid container storage<br>shall comply with 5.1.3.5.12.<br>11.3.2.5 Cylinder and container storage locations shall comply<br>with 5.1.3.3.1.7 with respect to temperature limitations.<br>11.3.2.6 Cylinder or container restraints shall comply with<br>11.6.2.3.<br>11.3.2.7 Smoking, open flames, electric heating elements, and<br>other sources of ignition shall be prohibited within | A 034 | | |

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storage locations
and within 6.1 m (20 ft) of outside storage locations.
11.3.2.8 Cylinder valve protection caps shall 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

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| A 034 | Continued From page 37<br>gate of the<br>storage room or enclosure.<br>11.3.4.2 The sign shall include the following wording as a<br>minimum:<br>CAUTION:<br>OXIDIZING GAS(ES) STORED WITHIN<br>NO SMOKING<br>2012 Edition<br><br>Based on observation, and interview, the facility failed to ensure that:<br>1. All medications were stored in separate compartments for each resident.<br>2. Oxygen cylinder tanks were stored securely, protected from accidental damage or dislocation.<br><br>These widespread deficient practices have the potential for all 16 (R #s 1-16) residents listed on the resident census, provided by the Administrator on on 08/12/19, to be at risk if:<br>1. Direct Care Staff (DCS) give the wrong narcotic medication because they are all being stored together and not separated into separate compartments..<br>2. An oxygen cylinder tank were to fall over damaging the valve, causing it to depressurize, and become a missile.<br><br>The findings are:<br><br>Findings related to narcotic medications<br><br>A. On 08/13/19 at 5:46 pm, during observation and tour of the facility, it was observed that the narcotic medications for 13 residents were not being stored in separate compartments for each resident. | A 034 | | |

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| A 034 | Continued From page 38<br><br>B. On 08/13/19 at 5:46 pm, during an interview, DCS #7 confirmed that the narcotic medications were not stored in separate compartments for each resident.<br><br>Findings related to oxygen storage<br><br>C. On 08/13/19 at 12:01 pm, during observation of the oxygen storage room, 10 tall oxygen cylinder tanks were observed to not be secured and were free standing.<br><br>D. On 08/13/19 at 12:01 pm, during an interview, the Head of Maintenance (HM) confirmed that there were 10 tall oxygen cylinder tanks in the oxygen storage room that were not secured and were free standing. | A 034 | | |
| A 035 | 7 NMAC 8.2.35 Medication<br><br>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.<br>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.<br>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 | A 035 | | |

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| A 035 | Continued From page 39 | A 035 | | |

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 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

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| A 035 | Continued From page 40<br>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:<br>(1) the resident's name;<br>(2) any known allergies to medication that the resident has;<br>(3) the name of the resident's PCP or the prescriber of the medication;<br>(4) the diagnosis or reason for the medication;<br>(5) the name of the medication, including the drug product brand name and the generic name;<br>(6) notation if the medication is a schedule II-IV drug;<br>(7) the dosage of the medication;<br>(8) the strength of the medication;<br>(9) the frequency or how often the medication is to be taken or given;<br>(10) the route of delivery for the medication (mouth, eye, ear, other);<br>(11) the method of delivery for the medication (pills, drops, IM injection, other);<br>(12) the date that the medication was started or discontinued;<br>(13) any change in the medication order;<br>(14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order;<br>(15) the date and time that the medication is self-administered, administered with assistance or is administered;<br>(16) the initials and signature of the person assisting with or administering the medication;<br>(17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.);<br>(18) any refused dose of medication;<br>(19) any missed dose of medication; and | A 035 | | |

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| A 035 | Continued From page 41<br>(20) any medication error.<br>H. No medication shall be stopped or started without specific orders from the primary care physician.<br>I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber.<br>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.<br>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:<br>(1) the resident's name;<br>(2) the name of the medication;<br>(3) the date that the prescription was issued;<br>(4) the prescribed dosage and the instructions for administration of the medication; and<br>(5) the name and title of the prescriber.<br>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.<br>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.<br>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).<br>[7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] | A 035 | | |

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| A 035 | Continued From page 42<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.35 H<br><br>Based on record review and interview, the facility failed to ensure that medications, including over-the-counter medications were not started/given without a physician's order.<br><br>This deficient practice has the potential for all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 08/12/19, to be at risk of harm, illness, or death if the residents are taking medications without a physician's.<br><br>The findings are:<br><br>A. Record review of R #1's [redacted]/19 thru [redacted]/19 Medication Administration Record (MAR) revealed that the Direct Care Staff (DCS) were assisting R #1 with the following medications without an accompanying physician's order:<br>[redacted]<br><br>B. On 08/15/19 at 12:55 pm, during an interview, the Administrator confirmed that the DCS were assisting R#1 with the above listed medication without a physician's order.<br><br>C. Record review of R #2's [redacted]/19 thru [redacted]/19 MAR revealed that the DCS were | A 035 | | |

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| A 035 | Continued From page 43<br>assisting R #2 with the following medications without an accompanying physician's order:<br>[redacted]<br>D. On 08/15/19 at 1:05 pm, during an interview, the Administrator confirmed that the DCS were assisting R #2 with the above listed medications without an accompanying physician's order.<br>E. Record review of R #4's [redacted]/19 thru [redacted]/19 MAR revealed that the DCS were assisting R #4 with the medication<br>[redacted]<br>F. On [redacted]/19 at 4:45 pm, during an interview, the Administrator confirmed the DCS were assisting R #4 with the medication<br>[redacted] | A 035 | | |
| A 036 | 7 NMAC 8.2.36 Nutrition<br>NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines | A 036 | | |

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| A 036 | Continued From page 44<br>shall not be considered a source of snacks.<br>A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements.<br>(1) Meal service. The facility shall:<br>(a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available;<br>(b) provide snacks of nourishing quality and post on the daily menu;<br>(c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences;<br>(d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle;<br>(e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets;<br>(f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room;<br>(g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and<br>(h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat.<br>(2) Staff in-service training. The facility shall | A 036 | | |

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| A 036 | Continued From page 45<br>provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes:<br>(a) instruction in proper food storage;<br>(b) preparation and serving food;<br>(c) safety in food handling;<br>(d) appropriate personal hygiene; and<br>(e) infectious and communicable disease control.<br>B. Dietary records. The facility shall maintain the following documentation onsite:<br>(1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days;<br>(2) a systematic record of therapeutic diets as prescribed by a PCP;<br>(3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and<br>(4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days.<br>C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC.<br>(1) Kitchen sanitation.<br>(a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning.<br>(b) Utensils shall be stored in a clean, dry place protected from contamination.<br>(c) The walls, ceiling and floors of all rooms that | A 036 | | |

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food or drink is stored, prepared or served shall be kept clean and in good repair.
(2) Washing and sanitizing kitchenware.
(a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing.
(b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff.
(c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented.
(d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection.
(3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels.
(4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner.
(5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority.
D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations

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| A 036 | Continued From page 47<br>governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC.<br>(1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents.<br>(2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read.<br>(a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit.<br>(b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below.<br>(3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days.<br>(4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained.<br>(5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC.<br>(6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. | A 036 | | |

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| A 036 | Continued From page 48<br>The facility shall not use home-canned foods.<br>(7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin.<br>(8) The facility shall ensure the following:<br>(a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit;<br>(b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and<br>(c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts.<br>E. Milk.<br>(1) Raw milk shall not be used.<br>(2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk.<br>F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells.<br>[7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] | A 036 | | |

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| A 036 | Continued From page 49<br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.36 B (4)<br><br>Based on observation and interview the facility failed to ensure that a daily log of recorded temperatures for all facility freezers was maintained and available for review.<br><br>This deficient practice has the potential for all 16 (R#1-16) residents identified on the census provided by the Administrator on 08/12/19 to be at risk for injury or harm due to the possibility of being served spoiled food.<br><br>The findings are:<br><br>A. On 08/13/19 at 11:06 am, during observation of the kitchen the back and front freezers were observed to not have thermometers and there was no daily logs of recorded temperatures available for review.<br><br>B. On 08/13/19 at 11:12 am, during an interview, DCS #4 confirmed the there were no thermometers or daily logs of recorded temperatures for the front or back freezers. | A 036 | | |
| A 042 | 7 NMAC 8.2.42 Maintenance of Building and Grounds<br><br>MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas:<br>A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from | A 042 | | |

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| GOOD LIFE MEMORY CARE | 800 JUAN ANDRES LANE LOS LUNAS, NM 87031 |

| (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 |
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| A 042 | Continued From page 50<br>accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard.<br>B. Floors. Floors shall be maintained stable, firm and free of tripping hazards.<br>[7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.42 A<br><br>NFPA 101, 2012 Edition<br>7.9.3 Periodic Testing of Emergency Lighting Equipment.<br>7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3.<br>7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows:<br>(1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2).<br>(2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.<br>(3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered.<br>(4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3).<br>(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the | A 042 | | |

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| A 042 | Continued From page 51<br>authority having jurisdiction.<br>7.9.3.1.2 Testing of required emergency lighting systems<br>shall be permitted to be conducted as follows:<br>(1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.<br>(2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.<br>(3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator.<br>(4) A visual inspection shall be performed at intervals not exceeding<br>30 days.<br>(5) Functional testing shall be conducted annually for a minimum<br>of 1 1/2 hours.<br>(6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1 1/2-hour test.<br>(7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.<br>7.10.9 Testing and Maintenance.<br>7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days or shall be periodically monitored in accordance with 7.9.3.1.3.<br><br>Based on record review and interview, the facility failed to complete monthly and annual testing of the emergency lighting system and exit signs. This deficient practice has the potential for all 16 (R #1-16) residents identified on the census provided by the Administrator on 08/12/19, to be at risk of harm if unable to see their path to the | A 042 | | |

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| A 042 | Continued From page 52<br>exit when evacuating the building in an emergency. The findings are:<br><br>A. Record review of the last facility annual inspection of the emergency lighting revealed it was dated 10/06/16. There were no other records of testing of the emergency lighting.<br><br>B. On 08/13/19 at 12:24 pm, during a interview, the Administrator confirmed that the emergency lighting has not been tested monthly and there are no records of monthly testing. | A 042 | | |
| A 045 | 7 NMAC 8.2.45 Water<br><br>WATER: Pursuant to the current New Mexico drinking water requirements, 7.6.2.9 NMAC.<br>A. The water supply system shall be constructed, protected, operated and maintained in conformance with applicable local, state and federal laws, ordinances and regulations.<br>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.<br>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.<br>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. | A 045 | | |

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| A 045 | Continued From page 53<br><br>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.<br>[7.8.2.45 NMAC - Rp, 7.8.2.46 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>Refer to 7.8.2.45 E<br><br>Based on observation and interview the facility failed to maintain the hot water temperature accessible to residents at a maximum of 110 degrees Fahrenheit. This deficient practice has the potential for all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 08/12/19 to be at risk of being scalded by too hot of a water temperature. The findings are:<br><br>A. On 08/13/19 at 12:01 pm, during observation and tour of the facility with the Head of Maintenance (HM) the following hot water temperatures were observed:<br>1. Resident Room #3's bathroom sink was observed to be 120 degrees Fahrenheit.<br>2. Resident Room #10's bathroom sink was observed to be 116 degrees Fahrenheit.<br>3. Resident Room #14's bathroom sink was observed to be 118 degrees Fahrenheit.<br><br>B. On 08/13/19 at 12:01 pm, during an interview, the HM confirmed the hot water temperature | A 045 | | |

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| A 045 | Continued From page 54<br>findings listed above. | A 045 | | |
| A 049 | 7 NMAC 8.2.49 Doors<br><br>DOORS:<br>A. No door in any means of egress shall be locked against egress when the building is occupied.<br>(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.<br>(2) If locks are not readily operable by all occupants within the building, the locks must: 1) unlock upon activation of the fire detection or sprinkler system and 2) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written approval from the building, fire and licensing authorities having jurisdiction.<br>B. All exit doors shall have a minimum width of thirty-six (36) inches.<br>(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.<br>(2) Facilities with a capacity of fifty (50) or more residents must provide panic hardware at the exit doors.<br>(3) No door or path of travel to a means of egress shall be less than twenty-eight (28) inches wide.<br>C. All resident sleeping room doors must be at least one and three-quarters (1 3/4) inch solid core construction.<br>D. Bathroom doors may be twenty-four (24) inches wide. Facilities with four (4) or more residents shall have at least one bathroom for | A 049 | | |

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| A 049 | Continued From page 55<br>every eight (8) residents with a door clearance of thirty-six (36) inches for access by persons with disabilities.<br>E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside.<br>F. All doors shall readily open from the inside.<br>G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms.<br>[7.8.2.49 NMAC - Rp, 7.8.2.50 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.49 A F<br><br>Based on observation and interview, the facility failed to ensure that:<br>1. No doors in any means of egress could be locked against egress.<br>2. All doors could be readily opened from the inside when locked.<br><br>This deficient practice has the potential for all 16 (R #s 1-16) memory care residents listed on the resident census, provided by the Administrator on 08/12/19, to be at risk of injury or harm if a fire or other emergency requiring evacuation occurs and they become trapped because the:<br>1. Resident room and bathroom doors are locked and residents are cognitively and/or physically unable to readily open them.<br>2. Doors to any path of egress of any egress path are locked and do not readily open.<br><br>The findings are:<br><br>Findings related to doors locked against egress:<br><br>A. On 08/13/19 at 12:01 pm, during observation | A 049 | | |

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| A 049 | Continued From page 56<br>and tour of the facility, a shared bathroom for resident rooms #s 14 and 15 had door locks that could be locked against egress and did not readily open.<br><br>B. On 08/13/19 at 12:24 pm, during an interview, the Administrator confirmed the the doors were/could be locked and did not readily open. In addition she confirmed that it was possible for a resident to get locked inside the bathroom.<br><br>Findings related to doors not readily opened from the inside in one motion:<br><br>C. On 08/13/19 at 12:01 pm, during observation with the Head of Maintenance (HM), the doors for all 16 (1-16) resident rooms were observed to not readily open from the inside when locked. The lock was observed to not unlock automatically when the handle was lifted/lowered, without first having to be unlocked with a separate motion.<br><br>D. On 08/13/19 at 12:01 pm, during an interview with the HM, he confirmed that the locks on all 16 (1-16) resident rooms were observed to not readily open from the inside when locked and would not unlock automatically when the handle was lifted/lowered, without first having to be unlocked with a separate motion. | A 049 | | |
| A 061 | 7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip<br><br>FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT:<br>A. Fire alarm system. Facilities with four (4) or 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 | A 061 | | |

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| A 061 | Continued From page 57<br>jurisdiction.<br>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.<br>(1) Detectors shall be powered by the house electrical service and have battery back up.<br>(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.<br>(3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing.<br>(4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service.<br>[7.8.2.61 NMAC - Rp, 7.8.2.60 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.61 A<br><br>NFPA 101, 2012 Edition<br>7.9.3 Periodic Testing of Emergency Lighting Equipment.<br>7.9.3.1 Required emergency lighting systems shall be tested in<br>accordance with one of the three options offered by 7.9.3.1.1,<br>7.9.3.1.2, or 7.9.3.1.3.<br>7.9.3.1.1 Testing of required emergency lighting systems<br>shall be permitted to be conducted as follows:<br>(1) Functional testing shall be conducted monthly, with a<br>minimum of 3 weeks and a maximum of 5 weeks | A 061 | | |

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| A 061 | Continued From page 58 | A 061 | | |

between
tests, for not less than 30 seconds, except as otherwise
permitted by 7.9.3.1.1(2).
(2)*The test interval shall be permitted to be extended beyond
30 days with the approval of the authority having jurisdiction.
(3) Functional testing shall be conducted annually for a minimum
of 11?2 hours if the emergency lighting system is battery
powered.
(4) The emergency lighting equipment shall be fully operational
for the duration of the tests required by 7.9.3.1.1(1)
and (3).
(5) Written records of visual inspections and tests shall be
kept by the owner for inspection by the authority having
jurisdiction.
7.9.3.1.2 Testing of required emergency lighting systems
shall be permitted to be conducted as follows:
(1) Self-testing/self-diagnostic battery-operated emergency
lighting equipment shall be provided.
(2) Not less than once every 30 days, self-testing/self-diagnostic
battery-operated emergency lighting equipment shall automatically
perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.
(3) Self-testing/self-diagnostic battery-operated emergency
lighting equipment shall indicate failures by a status indicator.
(4) A visual inspection shall be performed at

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| A 061 | Continued From page 59<br>intervals not exceeding 30 days.<br>(5) Functional testing shall be conducted annually for a minimum of 11/2 hours.<br>(6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 11?2-hour test.<br>(7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.<br><br>7.10.9 Testing and Maintenance.<br>7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days or shall be periodically monitored in accordance with 7.9.3.1.3.<br>7.10.9.2 Testing. Exit signs connected to, or provided with, a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3.<br><br>Based on record review and interview, the facility failed to have the fire alarm inspected annually. This deficient practice has the potential for all 16 (R # 1-16) residents identified on the census provided by the Administrator on 08/12/19, to be at risk of injury or death if residents and staff do not know there is a fire and the alarm system doesn't work properly. | A 061 | | |

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| A 061 | Continued From page 60<br><br>The findings are:<br><br>A. Record review of the annual inspection of the fire alarm system revealed it was last inspected on 10/12/16.<br><br>B. On 08/14/19 at 9:40 am, during an interview, the Administrator confirmed the fire alarm had not been inspected since 10/12/16. | A 061 | | |
| A 062 | 7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System<br><br>AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Facilities with nine (9) or more residents shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. [7.8.2.62 NMAC - Rp, 7.8.2.61 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>Refer to 7.8.2.62 & National Fire and Protection Association (NFPA)<br><br>Reference NFPA 13<br>Section 1-5.1 Maintenance:<br>A sprinkler system installed under this standard shall be properly maintained for efficient service. The owner is responsible for the condition of the sprinkler system and shall use due diligence in keeping the system in good operating condition.<br><br>Reference: NFPA 13, Sect. 1-6.1 states that a | A 062 | | |

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| A 062 | Continued From page 61<br>building, where protected by an automatic sprinkler system installation, shall be provided with sprinklers in all areas.<br><br>Reference NFPA 25, 1-4.2<br>The responsibility for properly maintaining a water-based fire protection system shall be that of the owner(s) of the property. By means of periodic inspections, tests, and maintenance, the equipment shall be shown to be in good operating condition, or any defects or impairments shall be revealed.<br>Inspection, testing, and maintenance shall be implemented in accordance with procedures meeting or exceeding those established in this document and in accordance with the manufacturer's instructions. These tasks shall be performed by personnel who have developed competence through training and experience.<br><br>Reference NFPA 25, 1-4.4<br>The owner or occupant promptly shall correct or repair deficiencies, damaged parts, or impairments found while performing the inspection, test, and maintenance requirements of this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor.<br><br>Based on record review, observation, and interview, the facility failed to have documentation that the automatic fire protection (sprinkler) system had:<br>1. Been tested and inspected quarterly and annually.<br>2. 6 replacement sprinkler heads and a wrench to change them with.<br><br>This deficient practice has the potential for all 16 (R #s 1-16) residents identified on the census | A 062 | | |

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| A 062 | Continued From page 62<br>provided by the Administrator on 08/12/19, to be at risk of injury or death in the event of a fire if:<br>1. The sprinkler system doesn't work properly.<br>2. If there are not enough sprinkler heads or a wrench to replace damaged sprinkler heads.<br><br>The findings are:<br><br>A. Record review of facility records revealed the automatic fire protection (sprinkler) system was last inspected on 10/13/16.<br><br>B. On 08/13/19 at 9:50 am, during observation and tour of the facility, it was observed there were only 4 replacement sprinkler heads and no wrench to replace them with in the red box where they are suppose to be kept.<br><br>C. On 08/13/19 at 9:50 am, during an interview, the Head of Maintenance (HM) confirmed the last inspection and testing of the automatic fire protection (sprinkler) system was dated 10/13/16, there were only 4 replacement sprinkler heads, and no wrench to replace them with.<br><br>D. On 08/14/19 at 9:40 am, during an interview, the Administrator confirmed that none of the facility fire safety systems had been inspected since 10/13/16. | A 062 | | |
| A 063 | 7 NMAC 8.2.63 Fire Extinguishers<br><br>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.<br>A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers:<br>(1) one (1) extinguisher located in the kitchen or | A 063 | | |

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| A 063 | Continued From page 63<br>food preparation area;<br>(2) one (1) extinguisher centrally located in the facility;<br>(3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection;<br>(4) the maximum distance between fire extinguishers shall be fifty (50) feet.<br>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.<br>[7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.63 A (3) B<br><br>Based on observation, record review, and interview, the facility failed to ensure that the 2 facility fire extinguishers were inspected annually and monthly.<br><br>This deficient practice has the potential for all 16 (R #s 1-16) residents listed on the census provided by the Administrator on 08/12/19 and all occupants of the building, to be at risk of injury or death if there is a fire and the fire extinguishers does not work properly.<br><br>The findings are:<br><br>A. On 08/14/19 at 9:40 am, during observation of the inspection tags for the 2 facility fire extinguishers revealed no inspections were conducted after the following dates:<br>1. Monthly inspection was last conducted in | A 063 | | |

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| A 063 | Continued From page 64<br>October, 2017.<br>2. Annual inspection was last conducted in October, 2016.<br><br>B. On 08/14/19 at 9:40 am, during an interview with the Administrator, she confirmed that 2 of 2 fire extinguishers had not been inspected since the following dates:<br>1. Monthly inspection was last conducted in October, 2017.<br>2. Annual inspection was last conducted in October, 2016.<br><br>C. Record review of facility Fire Safety and Evacuation policy revealed it stated, "[Facility Name] managers or maintenance persons will check the fire extinguishers monthly and mark it on the extinguishers' tags. All our fire extinguishers must be inspected yearly and recharged as needed by a professional service." | A 063 | | |
| A 065 | 7 NMAC 8.2.65 Fire Drills<br><br>FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented.<br>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.<br>B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show:<br>(1) the date of the drill;<br>(2) the time of the drill;<br>(3) the number of staff participating in the drill;<br>(4) any problem noted during the drill; and<br>(5) the evacuation time in total minutes. | A 065 | | |

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| A 065 | Continued From page 65<br>C. If applicable, the local fire department may be requested to supervise and participate in fire drills.<br>[7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>Refer to 7.8.2.65 A. B (5)<br><br>Based on record review and interview the facility failed to:<br>1. Ensure a fire drill during each 8 hour (day, evening, night) each quarter,<br>2. Document the evacuation times in total minutes.<br><br>This deficient practice has the potential for harm and/or death for all 16 (R #s 1-16) residents identified on the census provided by the administrator on 08/12/19 if:<br>1. Residents and staff are not having fire drills at all times of the day, evening, and night.<br>2. Direct Care Staff (DCS) do not realize that the evacuation time is too lengthy for an efficient and safe evacuation.<br><br>The findings are:<br><br>A. Record review of the facility's Fire Safety and Evacuation policy stated, "We have one fire drill per shift per quarter. . . . Graveyard shift fire drills are held at the end of the graveyard shift when morning shift comes in."<br><br>B. Record review of the fire drills from September 2018 through August 2019 revealed:<br>1. There were no fire drills done at night from | A 065 | | |

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| A 065 | Continued From page 66<br>September 2018 through August 2019 (12 months).<br>2. There were no evacuation times in total minutes for the 12 months.<br><br>C. On 05/02/19 at 8:30 am, during an interview, DCS #7 confirmed that all fire drills are completed during the day and evacuation time was not being completed. | A 065 | | |
| A 068 | 7 NMAC 8.2.68 Hospice<br><br>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.<br>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.<br>(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.<br>(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.<br>(3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour | A 068 | | |

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| A 068 | Continued From page 67 | A 068 | | |

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

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| A 068 | Continued From page 68 | A 068 | | |

training specific to the resident for all direct care staff.
(2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following:
(a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC;
(b) what services are to be provided;
(c) who will provide the services;
(d) how the services will be provided;
(e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process;
(f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and
(g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them.
(3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals:
(a) a physician;
(b) a physician extender (PA or NP);
(c) a licensed nurse (RN or LPN);
(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

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| A 068 | Continued From page 69<br>that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC.<br>(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.<br>(3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation.<br>(a) The facility shall provide individual records for each resident.<br>(b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record.<br>(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.<br>(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.<br>(6) The assisted living facility shall ensure the coordination of services with the hospice agency.<br>(a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs.<br>(b) The assisted living facility shall receive information and communication from the hospice staff at each visit.<br>(i) The information shall include the resident | A 068 | | |

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| A 068 | Continued From page 70 | A 068 | | |

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

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| A 068 | Continued From page 71<br>medicare or medicaid.<br>[7.8.2.68 NMAC - N, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.68 B (1)<br><br>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 training including one hour specific to resident's Individual Service Plan (ISP) annually when the facility is providing care and services for hospice residents.<br><br>This deficient practice has the potential for all 11 (R #s 1, 3-4, & 6-13) residents identified as receiving hospice services by the Administrator 08/12/19, to be at risk of harm or injury if DCS do not know the proper methods of providing care and services. The findings are:<br><br>A. Record review of DCS #1's employee file (date of hire 06/25/18) revealed only three hours Palliative/Hospice care training in the past year.<br><br>B. Record review of DCS #2's employee file (date of hire 06/17/18) revealed only three hours Palliative/Hospice care training in the past year.<br><br>C. Record review of DCS #3's employee file (date of hire 10/26/18) revealed only three hours Palliative/Hospice care training in the past year.<br><br>D. On 08/15/19 at 1:40 pm, during an interview, the Administrator confirmed the above listed palliative/hospice care training findings for DCS #s 1-3. | A 068 | | |