STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BUILDING: _____ B. WING _____	R-C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	800 JUAN ANDRES LANE LOS LUNAS, NM 87031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments The following deficiencies were cited during a Follow-up/Revisit survey completed on 07/01/21 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.	{A 000}		
{A 018}	7 NMAC 8.2.18 Policies POLICIES: The facility shall have and implement written personnel policies for the following: A. staff, private duty attendant and volunteer qualifications; B. staff, private duty attendant and volunteer conduct; C. staff, private duty attendant and volunteer training policies; D. staff and private duty attendant and volunteer criminal history screening; E. emergency procedures; F. medication administration; G. the retention and maintenance of current and past personnel records; and H. facilities shall maintain records and files that reflect compliance with NM and federal employment rules. [7.8.2.18 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.18 A C G Based on record review and interview, the facility failed to have all the required written personnel policies for staff and volunteers. This deficient practice could likely result in the 12	{A 018}		

Rita Grabler Administrator 7/27/2021

Division of Health Improvement

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{A 018}	Continued From page 1 (R #s 1-12) residents identified on the census provided by the Administrator on 06/17/21, 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: A. Record review of the facility's Policy and Procedure Manual (not dated) revealed that the following required personnel policies were missing: 1. Staff, private duty attendant, and volunteer qualifications. 2. Staff, private duty attendant, and volunteer training policies. 3. The retention and maintenance of current and past personnel records. B. On 07/01/21 at 1:44 pm, during an interview, the Administrator confirmed that there were no written facility personnel policies for the findings listed above. 7 NMAC 8.2.20 Admissions and Discharge	{A 018}	Immediately took action to assure all staff, volunteers and private duty staffs records, qualifications, and training files reflect compliance with New Mexico and Federal employment rules and the retention and maintenance of current and past personnel records are in place. Will in the future assure that all staff, volunteers and private duty staffs records, qualifications, and training files reflect compliance with New Mexico and Federal employment rules and the retention and maintenance of current and past personnel records are in place. Will have all new staff, volunteers and private duty staffs records, qualifications, and training files reflect compliance with New Mexico and Federal employment rules and the retention and maintenance of current and past personnel records are in place. Administrator will monitor on a quarterly basis that all staff, volunteers and private duty staffs records, qualifications, and training files reflect compliance with New Mexico and Federal employment rules and the retention and maintenance of current and past personnel records are in place. Corrective action is completed.	07/05/2021
{A 020}	ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules;	{A 020}		

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{A 020}	Continued From page 2 (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day	{A 020}		

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{A 020}	Continued From page 3 written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree	{A 020}		

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{A 020}	Continued From page 4 of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the	{A 020}		

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{A 020}	Continued From page 5 resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) Refer to Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.--	{A 020}	Immediately took action to assure each resident has an admission agreement that meets the New Mexico compliance. The admission agreement will include a refund upon Death Policy that is incompliance with NMAC 7.8.2.20 and Senate Bill 0335-2013, 30-day written notice if changes of cost and services and the Rights and responsibilities of reporting of incidents. Will in the future assure that each new resident has an admission agreement and that it includes a refund upon Death Policy that is incompliance with NMAC 7.8.2.20 and Senate Bill 0335-2013, 30-day written notice if changes of cost and services and the Rights and responsibilities of reporting of incidents. . Will assure that admission agreements are placed in each resident's chart. Administrator will monitor that admission agreements will meet the New Mexico compliance every time an admission agreement is completed. Corrective action is completed.	07/05/2021

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{A 020}	Continued From page 6 A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings. B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them. C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health." SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately. 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 a refund provision in case of death that is in compliance with 7.8.2.20 and Senate Bill	{A 020}		

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{A 020}	Continued From page 7 (SB) 0335 - 2013. This deficient practice could likely result in the residents/resident's estate to be at risk of not receiving monies owed or are aware of additional charges that may be incurred upon the death of a resident. The findings are: A. Record review of R #'s 1-4 Admission/Discharge Agreements revealed the following incorrect or missing information, 1. Refund provision in case of death that is in compliance with 7 NMAC 8.2.20 Regulations for Assisted Livings and Senate Bill (SB) 0335 - 2013. T 2. The Admission/Discharge Agreements indicated that there will be no refund upon death. B. On 07/01/21 at 1:44 pm, during an interview with the Administrator, she confirmed that R #s 1-4 Admission/Discharge Agreements: 1. Did not contain a refund upon death policy in compliance with the regulations or SB 0335-2013. 2. Incorrectly indicated that there would be no refund given upon death. 7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies	{A 020}		
{A 022}	FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their	{A 022}		

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{A 022}	Continued From page 8 surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained; (7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction; (8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks; (9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSES) rating, if applicable; (10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency	{A 022}		

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{A 022}	Continued From page 9 preparedness plan shall address two types of emergencies: (a) an emergency that affects just the facility; and (b) a region/area wide emergency; (11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC); (12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and (13) vaccination records for pets in the facility. B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority: (1) a copy of the facility license; (2) employee personnel records, including an application for employment, training records and personnel actions: (a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC; (b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and (3) a copy of all waivers or variances granted by the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents '	{A 022}		

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{A 022}	Continued From page 10 personal property; (5) meal availability and times; (6) resident use of common areas; (7) accommodation of resident ' s pets; and (8) resident use of electric blankets and appliances. D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas: (1) actions to be taken in case of accidents or emergencies; (2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission; (3) policy for medication errors; (4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.); (5) the handling of resident's funds, if the facility provides such services; (6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (12) admission agreement; (13) admission records; (14) resident records including maintenance and	{A 022}		

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{A 022}	Continued From page 11 record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (8) (10) (a-b) Based on record review and interview the facility failed to ensure that there were: 1. Records of 30 days of menus as served including snacks. 2. Written emergency evacuation plans for emergencies that affects just the facility and a community wide disaster to include transportation	{A 022}	Immediately took action to assure the Records of 30 days of menus as served including snacks and a Written emergency evacuation plans for emergencies that affects just the facility and a community wide disaster to include transportation resources and refuge area were all in compliance for the state of New Mexico. Will in the future assure the Records of 30 days of menus as served including snacks and a Written emergency evacuation plans for emergencies that affects just the facility and a community wide disaster to include transportation resources and refuge area were all in compliance for the state of New Mexico. Will assure the Records of 30 days of menus as served including snacks and a Written emergency evacuation plans for emergencies that affects just the facility and a community wide disaster to include transportation resources and refuge area were all in compliance for the state of New Mexico. Administrator will monitor weekly and assure the Records of 30 days of menus as served including snacks and Administrator will monitor monthly a Written emergency evacuation plans for emergencies that affects just the facility and a community wide disaster to include transportation resources and refuge area were all in compliance for the state of New Mexico. Corrective action is completed.	07/05/2021

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{A 022}	Continued From page 12 resources and refuge area. These deficient practices could likely result in all 12 (R #s 1-12) residents listed on the census provided by the Administrator 06/17/21, to be at risk of harm, injury, illness and/or death if there was no: 1. History of meals served to evaluate for adequate nutrition is not documented. 2. Evacuation plan if a disaster occurred, and the residents were unable to be safely evacuated from the facility or community. The findings are: A. Record request for the last 30 days of menus as served, including snacks revealed the facility had no documentation of the menus. B. Record request for the emergency evacuation plans for disasters or emergencies that affect either the facility or the community to include transportation resources and refuge areas, revealed no documentation of the emergency plans. Community-wide disasters revealed no documentation of a plan for the shelter or placement of residents during a community-wide disaster that effected just the facility or the entire community. C. On 07/01/21 at 1:44 pm, during an interview, the Administrator confirmed that the facility: 1. Did not have a record of the last 30 days of menus as served. 2. Did not have 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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	2237	A. BUILDING: _____ B. WING _____	R-C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	800 JUAN ANDRES LANE LOS LUNAS, NM 87031

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{A 035}	Continued From page 13	{A 035}		
{A 035}	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of	{A 035}		

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{A 035}	Continued From page 14 PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is	{A 035}		

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{A 035}	Continued From page 15 to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following:	{A 035}		

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{A 035}	Continued From page 16 (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 H Based on record review and interview, the facility failed to ensure for 4 (R #s 1-4) of 4 (R #s 1-4) residents whose Medication that medications, including over-the-counter medications were not started/given without a physician's order. This deficient practice could likely result in the residents to be at risk of harm, illness, or death if the residents are taking medications without a physician's order. The findings are:	{A 035}	Immediately took action to assure that no medications are given without an order. Will in the future assure that medications that are given to resident's will have an order in their chart to be in compliance for the state of New Mexico. Will maintain that each resident has orders for each medication they receive to comply for the state of New Mexico. Administrator and RN will monitor resident charts daily that medications have an order in each resident chart to be compliance for the state of New Mexico. Corrective action is completed.	07/05/2021

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{A 035}	Continued From page 17 A. Record review of R #'s 1-4 June, 2021 Medication Administration Records (MARs) revealed no documentation of any physician's orders for the mediations listed on the MARs. B. On 07/01/21 at 1:44 pm, during an interview with the Administrator, she confirmed the physician's orders were not with the MARs she provided and were not available for review.	{A 035}		
{A 042}	7 NMAC 8.2.42 Maintenance of Building and Grounds 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: 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 accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.42 A NFPA 101, 2012 Edition 7.9.3 Periodic Testing of Emergency Lighting Equipment.	{A 042}		

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{A 042}	Continued From page 18 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. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (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). (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 1 1/2 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 intervals not exceeding 30 days.	{A 042}	Immediately took action to assure that the facility emergency lighting equipment is in proper order and proper documentation is in the office. Will have emergency lighting tested monthly. Will in the future assure that proper maintenance is conducted monthly on facility emergency lighting equipment and proper records are kept. Administrator will train maintenance man to assure proper documentation shows the testing of emergency lighting equipment and documentation is done monthly. Administrator and Maintenance Man will monitor monthly that all emergency lighting equipment is tested and documented. Documentation will be in the Maintenance Binder in the office. Corrective action is completed.	07/05/2021

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{A 042}	Continued From page 19 (5) Functional testing shall be conducted annually for a minimum of 1 1/2 hours. (6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1 1/2-hour test. (7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.10.9 Testing and Maintenance. 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. Based on record review and interview, the facility failed to ensure that monthly and annual testing of the emergency lighting system and exit signs were conducted. This deficient practice could likely result in the 12 (R #s 1-12) residents identified on the census provided by the Administrator on 06/17/21, to be at risk of harm if they are unable to see their path to the exit when evacuating the building in an emergency. The findings are: A. Record request for the testing records for the emergency lighting and exit signs, revealed no documentation was provided or available for review to verify the testing of the emergency lighting equipment. B. On 06/17/21 at 1:44 pm, during a interview, the Administrator confirmed that she could not locate any documentation to verify the testing of the emergency lighting system or exit signs.	{A 042}		

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{A 061}	Continued From page 20	{A 061}		
{A 061}	7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: A. Fire alarm system. Facilities with four (4) or more residents shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction. B. Smoke and heat detection. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining and living room(s) must also be provided with smoke detectors. (1) Detectors shall be powered by the house electrical service and have battery back up. (2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room. (3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service. [7.8.2.61 NMAC - Rp, 7.8.2.60 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.61 A NFPA 101, 2012 Edition 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in	{A 061}	Immediately took action to assure that the facility fire alarm system is inspected annually and proper documentation is recorded and kept in the office. Will in the future assure that proper testing is conducted on facility fire alarm system and proper records are kept in the office. An annually inspection will be conducted by an outside entity. Administrator will assure that proper inspection of the fire alarm system is conducted annually, and the documentation will be kept in the office. Administrator and Maintenance Man will monitor annually that the fire alarm system is inspected and documented. All Documentation will be in the Life Safety Binder in the office. Corrective action is completed.	07/05/2021

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{A 061}	Continued From page 21 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. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (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). (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	{A 061}		

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{A 061}	Continued From page 22 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 intervals not exceeding 30 days. (5) Functional testing shall be conducted annually for a minimum of 11/2 hours. (6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 11?2-hour test. (7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.10.9 Testing and Maintenance. 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. 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.	{A 061}		

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{A 061}	Continued From page 23 Based on record review and interview, the facility failed to ensure that the fire alarm system was inspected annually. This deficient practice could likely result in the 12 (R #s 1-12) residents identified on the census provided by the Administrator on 06/17/21, to be at risk of injury or death if residents and staff do not know there is a fire because the alarm system doesn't work properly. The findings are: A. Record request for the annual fire alarm system inspection report revealed that no documentation was provided by the facility. B. On 07/01/21 at 1:44 pm, during an interview, the Administrator confirmed she could not locate any documentation to verify the annual fire alarm system inspection. 7 NMAC 8.2.65 Fire Drills	{A 061}		
{A 065}	FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and	{A 065}		

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{A 065}	Continued From page 24 (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.65 A. B (5) Based on record review and interview the facility failed to ensure there was a monthly fire drill conducted during each 8 hour shift (day, evening, night) each quarter. This deficient practice could likely result in the 12 (R #s 1-12) residents identified on the census provided by the Administrator on 06/17/21, to be at risk of harm, injury, or death if residents and staff are not conducting monthly fire drills on each 8 hour shift (day, evening, and night) per quarter. The findings are: A. Record request for the facility fire drill records revealed, no disorientation that fire drills had been conducted. B. On 07/01/21 at 1:44 pm, during an interview with the Administrator, she confirmed she could not find any documentation of fire drills being conducted and was unaware of the requirements per 7 NMAC.8.2.65. 7 NMAC 8.2.68 Hospice	{A 065}	Immediately took action to assure that the facility conducts a monthly fire drill to ensure the safety of staff and residents and Ensure a fire drill is conducted in each 8 hour (day, evening, night) each quarter and Document the evacuation times in total minute. The fire drill will include the date, time, number of staff that participated and any issues that were noted. Will in the future assure that a fire drill is conducted in each 8 hour shift each quarter and document the evacuation time in total minutes to ensure the safety of all inside the facility. The fire drill will include the date, time, number of staff that participated and any issues that were noted. Administrator will conduct a fire drill with each 8 hour shift each quarter and Documentation will be filed in maintenance binder. The fire drill will include the date, time, number of staff that participated and any issues that were noted. Administrator will be responsible for conducting a the fire drill quarterly. One fire drill will be performed with each 8 hour shift quarterly to be in compliance with the state of New Mexico. All documentation will be filed in the maintenance binder. The fire drill will include the date, time, number of staff that participated and any issues that were noted. Corrective action is completed.	07/05/2021
{A 068}		{A 068}		

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{A 068}	Continued From page 25 HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services.	{A 068}		

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	2237	A. BUILDING: _____ B. WING _____	R-C 07/01/2021

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{A 068}	Continued From page 26 (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services;	{A 068}		

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{A 068}	Continued From page 27 (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation.	{A 068}		

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{A 068}	Continued From page 28 (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility	{A 068}		

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{A 068}	Continued From page 29 or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified. E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.68 B (1) Based on record review and interview, the facility failed to ensure that Direct Care Staff (DCS) had received the required six (6) hours of palliative/hospice training including one hour specific to resident's Individual Service Plan (ISP)	{A 068}		

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{A 068}	Continued From page 30 annually when the facility is providing care and services for hospice residents. This deficient practice could likely result in the 6 (R #s 1-6) residents identified as receiving hospice services by the Administrator 06/17/21, to be at risk of harm or injury if the DCS do not know the proper methods of providing care and services. The findings are: A. Record request of DCS #s 1-5 annual hospice training records. revealed no documentation that the DCS had received the required (6) hours of hospice specific trainings. B. On 07/01/21 at 1:44 pm, during an interview, the Administrator confirmed she could not locate any hospice training records for DCS #s 1-5.	{A 068}	Immediately took action to assure that the staff has 6 hours of Hospice Care and proper documentation is placed in each staff file. Will in the future assure the facility is conducting an annual Hospice Care training for all direct care staff and that proper documentation is in each staff file. RN will provide the annual Hospice Care training to all direct care staff through an outside Hospice agency. The Hospice agency will provide all direct care staff that has completed the 6 hours of training with a certificate that is filed in the care staff's file. Administrator and RN will monitor annually that all direct care staff have been trained on Hospice Care and that records are kept in the office. The RN will provide training to all direct care new hire staff and an annual training will be conducted for all staff. Corrective action is completed.	07/05/2021