STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 as a result of a Full-Onsite/Complaint survey completed on 07/13/17 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. [redacted]	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents;not work while under the influence of alcohol or illegal drugs; (6) have evidence of education and (7) experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements	A 016		

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

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A 016	Continued From page 2 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.16 B (3) (6) Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In	A 016		

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A 016	Continued From page 3 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	A 016		

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A 016	Continued From page 4 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	A 016		

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

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A 016	Continued From page 6 the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1)During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2)Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview the facility failed to ensure for 4 (DCS #s 1-4) of 4 (DCS #s 1-4) Direct Care Staff files reviewed for compliance that the: 1. Employee Abuse Registry (EAR) clearances were received prior to hire. 2. The Caregivers Criminal History Screening Program (CCHSP) applications and fingerprints were submitted within twenty (20) days of hire. 3. Documentation/proof of the applications, fingerprints, and clearances were maintained and available for review. This deficient practice has the potential to affect the safety and welfare for all 39 (R #s 1-39) residents identified on the census provided by the	A 016		

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A 016	Continued From page 7 Supervisor on 07/07/17, if their care and services are being provided by staff who may have a previous history of abusing, neglecting, or exploiting residents and/or who may have a felony conviction. The findings are: A. Record review of DCS #1's (date of hire: 01/18/16) Final Registry Report dated 03/02/16, revealed, that the EAR clearance was not submitted/received prior to hire. B. Record review of DCS #2's (date of hire: 02/21/15) Final Registry Report dated 03/03/15 revealed, that the EAR clearance was not submitted/received prior to hire. D. Record review of DCS #3's (date of hire: 11/02/16) Final Registry Report, dated 07/10/17 revealed, that her EAR clearance was not submitted/received prior to hire. F. Record review of DCS #4's (date of hire: 06/06/17) Final Registry Report, dated 07/10/17 revealed, that her EAR clearance was not submitted/received prior to hire and the CCHSP application and fingerprints were not submitted within 20-days of hire. G. On 07/10/17 at 2:05 pm, during interview with the Supervisor, she confirmed that the EAR clearance for DCS #s 1-4 were not submitted/received prior to hire and for DCS #4 the CCHSP application and fingerprints were not submitted within 20-days of hire.	A 016	Reference: EMPLOYE ABUSE REGISTRY • All employee files have been audited as of 9/7/17. Any EAR clearance not submitted/ received have now been completed and filed in appropriate employee file. • CCHSP applications have been submitted accordingly. Any employee that is found non-compliant will be removed from direct care service. • Admin support staff was educated regarding hiring requirements and timeframe for completing EAR and CCHSP on 7/7/17 • An HR checklist that includes EAR and CCHSP requirements will be placed in each employee file. Admin support staff/receptionist will be trained by 9/30/17 regarding completion of EAR and CCHSP procedures. • EAR clearances will be submitted and filed *prior to date of hire* for new employees and CCHSP applications and fingerprints will be submitted *within 20 days of hire* • Administrator will be responsible for monitoring and ensuring continued compliance by auditing each new employee file within 7 days of date of hire and on quarterly basis.	9/30/17
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new	A 017		

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A 017	Continued From page 8 employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC,	A 017		

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A 017	Continued From page 9 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 C (1) (2) (3) (a) (b) (c) (d) (e) (4) (5) (6) (7) (8) (9) (10) (12) Based on record review and interview the facility failed to ensure for 4 (DCS #s 1-4) of 4 (DCS #s 1-4) Direct Care Staff employee training files reviewed for compliance received the 12-hours of orientation and annual training. This deficient practice has the potential for 39 (R #s 1-39) residents identified on the census provided by the Supervisor on 07/07/17, to be at risk of harm or injury if staff have not received training on the proper methods of providing care, and services. The findings are: A. Record review of DCS #1's training file revealed missing documentation for the required trainings: 1. Fire safety and evacuation training. 2. First aid. 3. Safe food handling practices to include: a. Instructions in proper storage. b. Preparation and serving of food. c. Safety in food handling. d. Appropriate personal hygiene. 4. Confidentiality of records and resident information. 5. Resident rights. 6. Smoking policy for staff. 7. Methods to provide quality resident care. 8. Emergency procedures. 9. Individual Service Plan implementation. B. Record review of DCS #2's training file revealed missing documentation for the required	A 017	Reference: STAFF TRAINING • Employee files have been audited as of 9/7/17 • Records of completed trainings have been updated/filed accordingly in each employee file • Training sessions have been scheduled on a monthly basis for current employees • New hires will receive 16 hours of supervision and 12 hours of training and education prior to providing direct care services independently • All staff will be provided with 12 hours of training and education annually • Current employees are scheduled to complete 12 hours of training on an annual basis and will include: New Hire training shall include the following: 1. Fire safety and evacuation training 2. First aid 3. Safe food handling practices to include: a. Instructions in proper storage b. Preparation and serving of food c. Safety in food handling d. Appropriate personal hygiene 4. Confidentiality of records and resident information 5. Resident rights 6. Smoking policy for staff 7. Methods to provide quality resident care 8. Emergency procedures 9. Individual Service Plan implementation • The administrator will be responsible to monitor and coordinate that new hires receive 16 hours of orientation/training and current staff receive 12 hours of training per year	9/30/17

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A 017	Continued From page 10 training's: 1. Fire safety and evacuation training. 2. First aid. 3. Safe food handling practices to include: a. Instructions in proper storage. b. Preparation and serving of food. c. Safety in food handling. d. Appropriate personal hygiene. e. Infectious and communicable disease control. 4. Confidentiality of records and resident information. 5. Resident rights. 6. Smoking policy. 7. Methods to provide quality resident care. 8. Emergency procedures. 9. Individual Service Plan implementation. C. Record review of DCS #3's training file revealed missing documentation for the required training's: 1. First aid. 2. Safe food handling practices to include: a. Instructions in proper storage. b. Preparation and serving of food. c. Safety in food handling. d. Appropriate personal hygiene. e. Infectious and communicable disease control. 3. Confidentiality of records and resident information. 4. Reporting requirements for abuse, neglect or exploitation. 5. Smoking policy. 6. Methods to provide quality resident care. 7. Emergency procedures. 8. Individual Service Plan implementation. D. Record review of DCS #4's training file revealed missing documentation for the required	A 017		

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A 017	Continued From page 11 training's: 1. Fire safety and evacuation training. 2. First aid. 3. Confidentiality of records and resident information. 4. Infection control. 5. Smoking policy. 6. Emergency procedures. 7. Individual Service Plan implementation. E. On 07/10/17 at 2:05 pm, during an interview with the Supervisor, she confirmed that there was no documentation maintained in the training files for DCS #s 1-4 that would confirm whether or not they had completed the twelve (12) hours of orientation/annual trainings listed above, and she did not know if DCS #s 1-4 had completed the training's listed above.	A 017		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge;	A 020		

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A 020	Continued From page 12 (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 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	A 020		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 020	Continued From page 13 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 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.	A 020		

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A 020	Continued From page 15 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 C (1) D (1) Based on record review and interview the facility failed to ensure for 2 (R #s 5 & 6) of 2 (R #s 5 & 6) residents receiving hospice services: 1. That an Admission/Retention team meeting was convened prior to accepting/retaining residents that choose to receive hospice services from an outside provider. 2. That the Individual Service Plan (ISP) included documentation of coordination of care between the facility and hospice provider. These deficient practices have the potential for residents on hospice to be at risk of harm if the: 1. The Direct Care Staff (DCS) are not able to provide the higher level of care and services residents on hospice may require. 2. DCS do not know what services hospice provides and/or what services they are to provide for the resident. The findings are: A. Record review of R #5's resident chart revealed no documentation that a team meeting	A 020	Reference: ADMISSIONS AND DISCHARGE • As of 9/1/17, hospice residents' charts were audited • ISPs were updated on 7/8/17 by nurse staff, and documentation filed in resident chart • An admission/retention team meeting will be conducted prior to a resident being admitted or retained on hospice care • An Individual Service Plan that includes documented coordination of care with hospice agency shall be completed at time of resident's admission to hospice services • Any team meetings and ISPs needed to bring resident records to compliance shall be completed by 10/18/17 • The administrator will be responsible for coordinating admission/retention team meetings and creation of ISP of the resident that is admitted for hospice services	10/18/17

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A 020	Continued From page 14 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 resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that	A 020		

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A 020	Continued From page 16 had been convened prior to his admission to hospice services on 02/08/16, and the ISP was revised when admitted to hospice to include coordination of care stating what care and services the hospice agency will provide. B. Record review of R #6's resident chart revealed, no documentation that a team meeting had been convened prior to his admission to hospice services on 05/11/16, and the ISP was revised when admitted to hospice to include coordination of care stating what care and services the hospice agency will provide. C. On 07/11/17 at 1:30 pm, during an interview with the administrator, she confirmed for R #s 5 & 6 there was no team meeting held before admittance to hospice and there is no revised ISPs done when admittance to hospice took place.	A 020		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at	A 025		

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

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A 025	Continued From page 18 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 A B E Based on record review and interview the facility failed to ensure for 4 (R #s 2, 4-6) of 6 (R #s 2-7) resident files that the Resident Evaluations were done prior to admission, at least every six months, reviewed, dated, and signed by a License Practical Nurse (LPN), Registered Nurse (RN) or Physicians Extender (PE). This deficient practice has the potential for residents to be at risk of not receiving the appropriate care and assistance needed as changes in their health status occurs. The findings are: A. Record review of R #2's resident file revealed, the resident evaluation was missing from the file. B. Record review of R #4's resident file revealed, the resident evaluation dated 07/07/15 was not done within the 15 days prior to the admission date of 08/14/15, and not reviewed or signed by a LPN, RN, or PE. No Evaluation has been reviewed/revised every six months since 04/19/16. C. Record review of R #5's resident file revealed, the resident evaluation dated 07/15/15, was not completed within the 15 days prior to the admission date of 06/29/15, and no evaluation has been reviewed/revised every six months since 07/15/15.	A 025	Reference: RESIDENT EVALUATION • Missing/incomplete documentations were updated and filed as of 7/8/17 • Appropriate assessments/ reassessments were completed by nurse staff on 7/8/17 • A new checklist for admission guidelines will be created, printed and included in new resident packets as a guide • Admin support/reception staff will be educated and trained regarding resident admission requirements and use of admission checklist by 9/30/17 • New residents will be evaluated within 15 days prior to admission • ISPs for residents will be completed within 10 days of admission • Reassessments of a resident will be completed every six months or when there is a change in status • The administrator will be responsible for monitoring resident evaluations and reassessments in appropriate time frame in order to ensure compliance	9/30/17

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A 025	Continued From page 19 D. Record review of R #6's resident file revealed, the resident evaluation was reviewed on 01/08/16 and not again until 05/10/17. E. On 07/10/17 at 10:00 am, during interview with the Supervisor, she confirmed that: 1. The evaluations for R #2 were missing from the file. 2. R#4's evaluation was not done within 15-days prior to admission, not reviewed by a LPN, RN, or PE, and not reviewed at least at six months. 3. R #5's evaluation was not done within 15-days prior to admission and not done at least at six months. 4. R#6's evaluation was not done at least every six months.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following:	A 026	Reference: INDIVIDUAL SERVICE PLAN • An audit of residents' charts was completed and ISPs were filed appropriately in residents' charts as of 9/1/17 • An excel spreadsheet was created on 9/1/17 to log current ISPs with a complete list of due dates for 6-month reassessments • Resident ISPs will be updated, reviewed and signed by nurse staff by 10/31/17 • Admin support staff will be educated and trained regarding ISP requirements and timeframe according to stated regulations by 10/31/17 • New resident ISPs will be developed within 10 days of admission and current ISPs will be updated with change of condition • The administrator will be responsible for quarterly audits of medical charts to ensure compliance	10/31/17

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A 026	Continued From page 20 (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 (2) (3) Based on Record Review and interview the facility failed to ensure for 6 (R #s 2-7) of 6 (R #s 2-7) residents whose Individual Service Plans (ISP) reviewed for compliance were: 1. Completed within 10 days of admissions. 2. Updated at a minimum of every 6 months or when a change in conditions occurs. 3. Signed and dated as reviewed by a License Practical Nurse (LPN) Registered Nurse (RN) or Physician Extender (PE). This deficient practice has the potential for the	A 026		

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A 026	Continued From page 21 residents not to receive the appropriate care and assistance they need as changes in their health status occurs. The findings are: A. Record review of R #2's resident file revealed, the ISP was missing from the file. B. Record review of R #3's resident file revealed, that the ISP has no date, was not signed or dated and there is no other ISPs in the residents file. C. Record review of R #4's resident file revealed, the ISP dated and completed on 04/19/16, has not been reviewed and/or revised at a minimum of every six months. D. Record review of R #5's resident file revealed, the ISP dated and completed on 07/15/15, has not been reviewed and/or revised at a minimum of every six months, and has not been updated to include hospice services that began on 02/08/16. E. Record review of R #6's resident file revealed, the ISP dated 03/28/15 was not completed within 10 days of admission date of 03/04/15, the last ISP dated 01/08/16, has not been reviewed and/or revised at a minimum of every six months, and has not been updated to include hospice services that began on 05/11/16. F. Record review of R #7's resident file revealed, the ISP dated 05/10/17 was not completed within 10 days of admission date of 03/25/15, and was not reviewed or revised at least every six months until 05/10/17. G. On 07/10/17 at 10:00 am during an interview with the Supervisor she confirmed that: 1. R #2's ISP is missing from the residents file.	A 026		

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A 026	Continued From page 22 2. R #3's ISP has no date, was not signed or dated and there is no other ISPs in the file. 3. R #4's ISP has not been reviewed and/or revised at a minimum of every six months. 4. R #5's ISP has not been reviewed and/or revised at a minimum of every six months, and has not been updated to include hospice services that began on 02/08/16. 5. R #6's ISP was not completed within 10 days of admission date of 03/04/15, has not been reviewed and/or revised at a minimum of every six months, and has not been updated to include hospice services that began on 05/11/16. 6. R #7's ISP was not compeleted within 10 days of admission date of 05/10/17, and has not been reviewed or revised at six months until 05/10/17.	A 026		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission;	A 033		

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A 033	Continued From page 23 (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (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	A 033		

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A 033	Continued From page 24 chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m)have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances;	A 033		

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A 033	Continued From page 25 (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D 7 Based on record review and interview, the facility failed to ensure that residents' Medication Assistance Record (MAR) charts are secured and kept confidential. This deficient practice has the potential for all 39 (R #s 1-39) residents identified on the census provided by the Supervisor on 07/07/17, to be at risk of their personal information not being kept confidential if unauthorized persons can have easy access to the MAR files. The findings are: A. On 07/07/17 at 1:45 pm, during a tour of the facility it was observed that all residents MARs charts were not secured, left on top of medication carts in the dining room, and left unattended by staff. B. On 07/07/17 at 2:55 pm, during an interview	A 033	Reference: RESIDENT RIGHTS • Medication assisting staff were educated and trained on 7/8/17 regarding keeping resident information confidential and to secure MAR charts appropriately • Summary of instructions will be printed, laminated and available for staff on each med cart to maintain compliance by 9/30/17 • A new electronic MAR system is currently being implemented and will be in full use by 9/30/17 which will further protect resident data and confidentiality • By 10/31/17, all medication assisting caregivers will receive additional training on electronic MAR in order to maintain compliance as related to resident rights • The lead medication assisting caregiver will be responsible for monitoring staff compliance on a daily basis • The administrator will be responsible for providing staff with ongoing training and education regarding resident rights	10/31/17

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	2252	A. BUILDING: _____ B. WING _____	C 07/13/2017

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A 033	Continued From page 26 with the Administrator, she confirmed that all residents' MARs charts were not secured, left on top of the medication carts in the dining room, and left unattended by staff.	A 033		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's	A 034		

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A 034	Continued From page 27 name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (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	A 034		

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A 034	Continued From page 28 maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1)Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2)A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3)Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4)The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (3) (7) Reference NFPA 99 (Healthcare Facilities Code) 2012 Edition NFPA 99. 11.3 Cylinder and Container Storage Requirements. 11.3.1* Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3.	A 034		

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A 034	Continued From page 29 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. 11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. 11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour 11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations. 11.3.2.8 Cylinder valve protection caps shall 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	A 034		

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A 034	Continued From page 30 total volume equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 11.3.3.1 and 11.3.3.2. 11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not be required to be stored in enclosures. 11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. 11.3.3.3 When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders. 11.3.3.4 Individual small-size (A, B, D, or E) cylinders available for immediate use in patient care areas shall not be considered to be in storage. 11.3.3.5 Cylinders shall not be chained to portable or movable apparatus such as beds and oxygen tents. 11.3.4 Signs. 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following wording as a minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING 2012 Edition Based on observation and interview, the facility failed to ensure that: 1. Oxygen cylinder tanks were secured and stored correctly. 2. Medication refrigerator was secured. 3. Prescribed medications are available at	A 034		

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A 034	Continued From page 31 the facility. This deficient practice has the potential for all 39 (R #s 1-39) residents identified on the census provided by the Supervisor on 07/17/17, to be at risk of illness, injury or death if: 1. Oxygen cylinder tanks were to be knocked over and may act like a missile, and if a fire occurs, combustibles stored with oxygen cylinder tanks accelerates the fire. 2. The medication refrigerator is opened by residents and any or all medications are removed or ingested by residents. 3. The facility does not have the prescribed medications. The Findings for Oxygen A. On 07/11/17 at 10:15 am, during observation of R #8's room (#34), seventeen (17) unsecured oxygen cylinder tanks and twenty (20) secured oxygen cylinder tanks were stored in the room and no "oxygen in use" sign posted on the door. B. On 07/11/17 at 10:25 am, during observation of R #5's room (#32), there were twenty-one (21) unsecured oxygen cylinder tanks and five (5) unsecured oxygen cylinder tanks were stored in the room and no "oxygen in use" sign posted on the door. C. On 07/11/17 at 10:30 am, during observation of R #9's room (#17), there was one (1) unsecured oxygen cylinder tank and twenty-four (24) secured oxygen cylinder tanks stored in the room and no "oxygen in use" sign posted on the door. D. On 07/11/17 at 11:45 am, during an interview with the Supervisor, she confirmed that: 1. In R #8's room there were seventeen (17)	A 034	RE: OXYGEN • An audit was started on 8/28/17 to monitor daily and weekly usage of oxygen by residents in order to plan for appropriate storage space • On 9/1/17, appropriate staff was educated and trained regarding safe and proper storage of oxygen tanks • Oxygen racks were ordered and tanks secured or moved out of resident rooms • On 9/5/17, precautionary signs were created and displayed on doors of residents using oxygen • An appropriate storage space will be completed by 9/15/17. The storage room is an enclosed interior space with self-closing, positive latching hardware and locking mechanism. • The storage space will be ventilated, protected by an automatic sprinkler system and will be free of combustible materials • Safe and proper storage of oxygen will be included in staff orientation and training by 9/30/17 • Designated staff will be responsible for monitoring safe and proper storage of oxygen on a daily/weekly basis as of 9/30/17 in order to maintain compliance • The assistant manager will be responsible for monitoring safety and compliance of staff regarding storage of oxygen on a weekly basis • The administer will be responsible for completing semi-annual audit and monitoring records to ensure compliance	9/30/17

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A 034	Continued From page 32 unsecured oxygen cylinder tanks, twenty (20) secured oxygen cylinder tanks stored in the room and no "oxygen in use" sign posted on the door. 2. In R #5's room there were twenty-one (21) unsecured oxygen cylinder tanks and five (5) secured oxygen cylinder tanks stored in the room and no "oxygen in use" sign posted on the door. 3. In R #9's room there was one (1) unsecured oxygen cylinder tank and twenty-four (24) secured oxygen cylinder tanks stored in the room and no "oxygen in use" sign posted on the door. Findings for Medication Refrigerator E. On 07/13/17 at 8:30 am, during an observation and interview, it was observed that the Medication refrigerator did not have a lock. During an interview with the Medication Assist Coordinator, she confirmed that the Medication refrigerator did not have a lock. The Findings for Medications F. On 07/13/17 at 9:32 am, observation of the medication cart revealed, Ibuprofen (pain) 200 milligrams (mg), PRN (as needed) was still listed on the June 2017 MAR and 07/01/17 to 07/12/17 MAR for R #4. There was no physician's order for the medication to be discontinued (DC), and there was no medication. G. On 07/13/17 at 9:45 am, observation of the medication cart revealed, Ipratropium albuterol (shortness of breath) 2.5 mg-0.5 mg/3 milliliters (ml) PRN and Atropine 1% (excessive secretions) eye drops was still listed on the June 2017 MAR and 07/01/17- 7/12/17 MAR, for R #2 and there was no physician's order for the medication to be discontinued (DC), and there was no medication. H. On 07/13/17 at 9:50 am, during an interview	A 034	Re: MEDICATION REFRIGERATOR • As of 9/5/17, the medication refrigerator has been fitted with a lock and will be kept locked at all times • Checking the locked refrigerator will become part of the medication assisting staff's daily procedure • The lead medication assisting caregiver will be responsible for monitoring and ensuring compliance on a weekly basis RE: MEDICATIONS • On 7/7/17, medication orders were requested as needed for discharged meds • An audit of medication cart was completed on week of 7/10/17 and orders and med supplies were reconciled • A new electronic MAR system is currently being implemented and will be in full use by 9/30/17 which will support accuracy in medication orders and supplies • The lead medication assisting caregiver will be responsible for ongoing compliance completing a monthly audit to reconcile orders and med cart supplies • The administrator will be responsible for providing ongoing training, education for all medication assisting staff and will perform random audits to ensure compliance • By 10/31/17, all medication assisting caregivers will receive additional training on electronic MAR for improved oversight and accuracy of med cart management	9/5/17 10/31/17

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A 034	Continued From page 33 with the Medication Assist Coordinator, she confirmed that: 1. The Ibuprofen (pain) 200 milligrams (mg), PRN (as needed) was still listed on the June 2017 MAR and 07/01/17 to 07/12/17 MAR for R #4 and the facility did not have the medication. 2. Ipratropium albuterol 2.5 mg-0.5 mg/3 milliliters (ml) PRN and Atropine 1% (excessive secretions) eye drops was still listed on the June 2017 MAR and 07/01/17- 7/12/17 MAR, for R #2, and the facility did not have the medication.	A 034		
A 044	7 NMAC 8.2.44 Heating, Air-Conditioning and Ventilation HEATING, AIR-CONDITIONING AND VENTILATION: A. Heating, air-conditioning, piping, boilers and ventilation equipment shall be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities shall have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. B. The heating method used by the facility shall provide a minimum temperature of seventy (70) degrees fahrenheit, measured at three (3) feet above the floor, in all rooms used by the residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device shall be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances shall be permanently anchored and kept away from flammables such as curtains, bedcovering, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping	A 044		

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A 044	Continued From page 34 hazard or presents danger from electrical shock. D. Fireplaces and open flame heating shall not be utilized in sleeping rooms. E. Gas fired water heaters shall not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms. F. The facility shall be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means. G. All openings to the outside air used for ventilation shall be screened for the control of insects and rodents. Screen doors shall be equipped with self-closing devices. H. The facility shall have a system for maintaining the residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7.8.2.44 NMAC - Rp, 7.8.2.45 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.44 A Based on observation and interview the facility failed to ensure that the gas heating system was checked, tested, and maintained annually. This deficient practice has the potential for all 39 (R #s 1-39) residents identified on the census provided by the Supervisor on 07/07/17, to be at risk of illness and harm if the furnace stops working during cold weather and/or has a gas/carbon monoxide leak. The findings are: A. Record review of the facility's Maintenance file revealed that there was no documentation for	A 044	Re: HEATING, AIR-CONDITIONING AND VENTILATION • A plumbing company has been scheduled to check, test and perform maintenance on the gas heating system on 9/28/17 • Inspection, test and maintenance records will be kept on site and available for review • By 9/28/17, a calendar for regular maintenance of the gas heating system will be created to ensure compliance • By 9/28/17, the assistant manager and maintenance staff will trained regarding regulatory requirements and will be responsible for scheduling annual inspection • The administrator will be responsible for monitoring the scheduling and completion of the testing of the gas heating system on an annual basis	9/28/17

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A 044	Continued From page 35 annual inspections for the gas heater furnace. B. On 07/12/17 at 11:00 am, during an interview with the Assistant Manager, he confirmed that there was no documentation for annual gas heater inspections and could not confirm when the heater was last inspected.	A 044		
A 048	7 NMAC 8.2.48 Electrical System ELECTRICAL SYSTEM: A. All fuse and breaker boxes shall be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility shall know the location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances shall be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear. (2) Extension cords shall not be used. The use of a multi-socket united laboratories approved (U/L APPROVED) surge protector with integrated circuit breaker no greater than six (6) feet in length is permitted for the intended purpose and not as an extension cord. [7.8.2.48 NMAC - Rp, 7.8.2.49 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: GFCI 7.8.2.48 NFPA 70 National Electric Code 210.8 Ground Fault Circuit Interrupter Protection for Personnel	A 048		

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A 048	Continued From page 36 210.8 (B) Other than dwelling units. All 125 volt, single phase, 15 and 20 ampere receptacles installed in the locations specified in 210.8 (B)(1) through (8) shall have ground fault circuit interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception 1: to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow melting, de-icing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22 as applicable. Exception 2: to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2)shall be permitted for only those receptacles outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 6 ft. of the outside edge of the sink. Exception 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than	A 048		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 048	Continued From page 37 those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. 314.25: Covers and Canopies. In completed installations, each box shall have a cover, faceplate, lampholder, or luminaire canopy, except where the installation complies with 410.24(B) 406.5(F): Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. Based on observation and interview, the facility failed to ensure electrical outlets within 6 feet of a water supply are fitted with Ground Fault Circuit Interrupters sockets. This deficient practice has the potential for all 39 (R #s 1-39) residents identified on the census, provided by the Supervisor on 07/07/17, to be at risk of harm or death from electric shock. The findings are: A. On 07/11/16, at 3:00 pm, during an observation of the laundry room, it was observed that the washing machine was plugged into a socket that was not fitted with a GFCI, and an electrical outlet was within 6 feet of a water supply was not fitted with a GFCI. B. On 07/13/16, at 10:42 am, during interview with the Assistant Manager, he confirmed that the washing machine was not plugged into a GFCI socket and there is a socket within 6 feet of a water supply not protected with a GFCI.	A 048	Re: ELECTRICAL SYSTEM • As of 9/5/17, all electrical circuits in the two laundry rooms (two in each laundry room) have now been fitted with a Ground Fault Circuit Interrupter (GFCI) • By 9/30/17, assistant manager and maintenance staff will be educated and trained regarding electrical system regulations • Copies of appropriate section of the regulation will be kept with maintenance records for ongoing reference • The assistant manager and/or maintenance staff is responsible for monitoring safe usage of electrical equipment on day to day basis • The administrator is responsible for oversight of maintenance staff and compliance with regulatory requirements	9/5/17

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A 061	Continued From page 38	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 72 (2010 Edition) 14.2.1.1 Performance Verification. To ensure operational integrity, the system shall have an inspection, testing, and	A 061		

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A 061	Continued From page 39 maintenance program. 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer ' s published instructions. 14.2.1.1.2 Inspection, testing, and maintenance programs shall verify correct operation of the system. 14.2.1.2 Impairments. 14.2.1.2.1 The requirements of Section 10.19 shall be applicable when a system is impaired. 14.2.1.2.2 System defects and malfunctions shall be corrected. 14.2.1.2.3 If a defect or malfunction is not corrected at the conclusion of system inspection, testing, or maintenance, the system owner or the owner ' s designated representative shall be informed of the impairment in writing within 24 hours. 14.2.2 Responsibilities. 14.2.2.1* The property or building or system owner or the owner ' s designated representative shall be responsible for inspection, testing, and maintenance of the system and for alterations or additions to this system. 14.2.2.2 The delegation of responsibility shall be in writing, with a copy of such delegation provided to the authority having jurisdiction upon request. 14.2.2.3 Inspection, testing, or maintenance shall be permitted	A 061		

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A 061	Continued From page 40 to be done by the building or system owner or a person or organization other than the building or system owner if conducted under a written contract. Based on record review and interview the facility failed to ensure that the fire alarm circuit breaker is mechanically protected from being inadvertently turned to the "off" position. This deficient practice has the potential for all 39 (R # 1-39) residents on the census provided by the Supervisor on 07/07/17, to be at risk of injury or death if a fire was to occur and residents and staff do not know there is a fire and the alarm system is not working. The findings are: A. On 07/12/17 at 10:45 am, during observation and interview, it was observed that the circuit breaker for the Fire Alarm System revealed, it was not mechanically protected to prevent the alarm system from being inadvertently turned off. During an interview with the Assistant Manager, he confirmed that the circuit breaker for the Fire Alarm System is not mechanically protected.	A 061	Re: FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT • As of 9/5/17, the fire alarm circuit breaker is mechanically protected from being turned off • The assistant manager and maintenance staff will be educated and trained regarding fire alarms, smoke detectors and other equipment • Copies of appropriate sections of the regulation will be kept with maintenance records for ongoing reference • The administrator is responsible for providing training and education regarding fire alarms, smoke detectors and other equipment and is responsible for oversight of maintenance staff to ensure compliance	9/5/17
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show:	A 065	Re: FIRE DRILLS • A fire drill was completed for AM shift on 8/25/17. Fire drills are scheduled for PM shift on 9/13/17 and for midnight shift on 9/17/17 • An annual schedule for fire drills to be conducted for each shift was completed 9/1/17. This will include 1 fire drill per month and 1 fire drill per shift per quarter • The assistant manager and/or maintenance staff is responsible for scheduling and performing fire drills per shift and maintain records accordingly • The administrator is responsible for oversight of fire drills and to ensure ongoing compliance	9/1/17

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A 065	Continued From page 41 (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 (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 A. Based on record review and interview, the facility failed to conduct monthly fire drills. This deficient practice has the potential for all 39 (R #s 1-39) residents identified on the census provided by the Supervisor on 07/07/17, to be at risk of harm and/or death if the staff are not prepared to carry out a safe evacuation of residents and notification of the fire department in the event of a fire. The findings are: A. Record review of the facility's fire drills file, revealed that the last fire drill conducted was on 12/31/15. B. On 07/12/17 at 3:15 pm, during interview with the Administrator, she confirmed that the last fire drill was conducted 12/31/15.	A 065	FIRE DRILLS – continued Record Maintenance • As of 9/5/17, the Fire Safety and Maintenance records have been brought current to show records for fire drills and fire safety education conducted • The assistant manager and/or maintenance staff shall be responsible for maintaining current records of fire drills and safety training • The administrator is responsible for quarterly audit of fire drill records to ensure ongoing compliance	9/5/17
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall	A 068		

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A 068	Continued From page 42 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. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the	A 068		

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A 068	Continued From page 43 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; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice	A 068	Continued: HOSPICE • An audit of residents' charts was completed on 9/1/17 • An excel spreadsheet was created on 9/1/17 to log current ISPs with a complete list of due dates for 6-month reassessments • Resident ISPs will be updated, reviewed and signed by nurse staff by 10/31/17 • Resident ISPs will be developed prior to admission to hospice services • The administrator will be responsible for quarterly audits of medical charts to ensure compliance	10/31/17

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A 068	Continued From page 44 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) The facility shall provide individual records for each resident.	A 068		

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A 068	Continued From page 45 (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 or the hospice agency shall first be addressed with the facility administrator and the hospice	A 068		

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A 068	Continued From page 47 hospice provider. 3. A team meeting is held prior to accepting or retaining a hospice resident. This deficient practice has the potential for 2 (R #s 5 & 6) of 2 (R #s 5 & 6) residents receiving hospice services to be at risk of: 1. DCS not knowing the proper methods of providing hospice care and services. 2. DCS not knowing what services hospice provides and/or what services they are to provide for the resident. 3. Not receiving the higher level of care and services they need. The findings are: Findings for Hospice Training A. Record review of DCS #2's (date of hire: 02/21/15) staff file revealed, missing documentation for 6-hours of hospice training to include one (1) hour specific to the hospice resident's ISP. B. On 07/10/17 at 2:05 am, during an interview with the Supervisor, she confirmed that the required six (6) hours of hospice specific training documentation is missing from the training file for DCS #2's file and could not confirm if any hospice trainings took place. Findings for team meeting and ISPs C. Record review of R #5's resident chart revealed no documentation that a team meeting had been convened prior to his admission to hospice services on 02/08/16, and the ISP dated and completed 07/15/15 had not been reviewed and/or revised at a minimum of every six months, and has not been updated to include hospice services that began on 02/08/16. D. Record review of R #6's resident chart	A 068	Re: HOSPICE Staff Training • As of 8/8/17, an education and training session was provided to staff from hospice-specific provider/nurse • By 10/31/17, all direct care staff will receive required 6 hours of hospice training and documentation will be filed in personnel charts • Hospice education (6 hours) will be provided for new direct care employees • The Administrator is responsible for monitoring staff training and will audit employee charts on a semi-annual basis to ensure compliance Resident Chart • As of 9/1/17, hospice residents' charts were audited • ISPs were updated by 7/8/17 by nurse staff, and documentation filed in resident charts • Records of team meetings shall be updated and filed in resident chart as appropriate by 9/30/17 • All direct care staff will be educated and trained regarding hospice procedures and documentation by 10/31/2017 • An admission/retention team meeting will be conducted prior to a resident being admitted or retained on hospice care. ISPs will be completed prior to admission to hospice with reassessment every 6 months or when there is a change in status • The administrator is responsible for coordinating a team meeting prior to admission/retention to hospice care in order to ensure compliance	10/31/17 10/31/17

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A 068	Continued From page 46 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) C (2) D (2) (6) (a) Based on record review and interview the facility failed to ensure that: 1. Direct Care Staff (DCS) received an additional 6 hours of hospice specific training annually. 2. Individual Service Plan (ISP) reflects the coordination of care between the facility and the	A 068		

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A 068	Continued From page 48 revealed, no documentation that a team meeting had been convened prior to his admission to hospice services on 05/11/16, and the ISP dated 03/28/15 was not completed within 10 days of admission date of 03/04/15, the last ISP dated 01/08/16, had not been reviewed and/or revised at a minimum of every six months, and has not been updated to include hospice services that began on 05/11/16. E. On 07/10/17 at 10:00 am during an interview with the Supervisor she confirmed that: 1. R #5's ISP has not been reviewed and/or revised at a minimum of every six months. 2. R #6 ISP was not completed within 10 days of admission date of 03/04/15, and had not been reviewed and/or revised at a minimum of every six months. F. On 07/11/17 at 1:30 pm, during an interview with the administrator, she confirmed for R #s 5 & 6 there was no team meeting held before admittance to hospice and there is no revised ISPs done when admittance to hospice took place.	A 068		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health,	A 070		

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RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 070	Continued From page 49 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.70 D E Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an	A 070		

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A 070	Continued From page 50 employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the 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	A 070		

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A 070	Continued From page 51 department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per 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	A 070		

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A 070	Continued From page 52 nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. . . . E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The department and department of public safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico department of health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant , caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by department of public safety and the federal bureau of investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules.	A 070		

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A 070	Continued From page 53 The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1)During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2)Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview the facility failed to ensure for 4 (DCS #s 1-4) of 4 (DCS #s 1-4) Direct Care Staff files reviewed for compliance that the: 1. Employee Abuse Registry (EAR)	A 070		

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A 070	Continued From page 54 clearances were received prior to hire. 2. The Caregivers Criminal History Screening Program (CCHSP) applications and fingerprints were submitted within twenty (20) days of hire. 3. Documentation/proof of the applications, fingerprints, and clearances were maintained and available for review. This deficient practice has the potential to affect the safety and welfare for all residents if their care and services are being provided by staff who may have a previous history of abusing, neglecting, or exploiting residents and/or who may have a felony conviction. The findings are: A. Record review of DCS #1's (date of hire: 01/18/16) Final Registry Report dated 03/02/16, revealed, that the EAR clearance was not submitted/received prior to hire. B. Record review of DCS #2's (date of hire: 02/21/15) Final Registry Report dated 03/03/15 revealed, that the EAR clearance was not submitted/received prior to hire. D. Record review of DCS #3's (date of hire: 11/02/16) Final Registry Report, dated 07/10/17 revealed, that her EAR clearance was not submitted/received prior to hire. F. Record review of DCS #4's (date of hire: 06/06/17) Final Registry Report, dated 07/10/17 revealed, that her EAR clearance was not submitted/received prior to hire and the CCHSP application and fingerprints was not submitted within 20-days of hire. G. On 07/10/17 at 2:05 pm, during interview with the Supervisor, she confirmed that the EAR clearance for DCS #1-4 was not	A 070	Re: EAR/CCHSP and documentation/proof of applications • Admin support staff were educated regarding hiring requirements and timeframe for completing EAR and CCHSP on 7/7/17 • All employee files have been audited as of 9/7/17. Any EAR clearance not submitted/ received have been completed and filed in appropriate employee file • CCHSP applications have been submitted accordingly. Any employee that is found non-compliant will be removed from direct care service • As of 9/7/17, all new hires have complete EAR/CCHSP submitted and reports filed appropriately • The assistant manager is responsible for monitoring that all new hires have completed EAR *prior to start of employment* • The administrator is responsible for auditing and monitoring that CCHSP paperwork have been processed and in employee files *within 20 days of hiring.* • An audit of personnel charts shall be conducted on a quarterly basis	9/7/17

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A 070	Continued From page 55 submitted/received prior to hire and for DCS #4 the CCHSP application and fingerprints were not submitted within 20-days of hire.	A 070		