STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5399	A. BUILDING: _____ B. WING _____	C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR LIVING SYSTEMS	5 THOMAS RD BLDG I LOS LUNAS, NM 87031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited as a result of a Full-Onsite/Complaint survey completed on 01/16/18 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake NM#30219 was substantiated with deficiencies cited.	A 000		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (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;	A 017		

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A 017	Continued From page 1 (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 A C (2, 4, 5, 8, 10, 11, & 12) Based on record review and interview, the facility failed to ensure that all Direct Care Staff (DCS) whose training files were reviewed for compliance received training on: 1. 16 hours of supervised training (shadowing) prior to providing unsupervised care. 2. Confidentiality of records and resident information. 3. Infection control. 4. Smoking policy for staff, residents and visitors. 5. Medication assistance, including the certificate of training for staff that assist with medication delivery; and 6. The proper way to implement a resident's Individual Service Plans (ISP) for staff that assist with ISPs. These deficient practices have the potential for all 15 (R #s 2-16) residents identified on the resident census provided by Office Manager on 01/03/18	A 017		

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A 017	Continued From page 2	A 017		

to be at risk of harm if they are being provided care by staff who have not received proper training. The findings are:

A. Record review of DCS #1's training file (hire date 03/28/14), revealed no documentation that she received:

1. 16 hours of supervised training (shadowing) prior to providing unsupervised care.
2. Confidentiality of records and resident information.
3. Infection control.
4. Smoking policy for staff, residents and visitors.
5. Medication assistance, including the certificate of training for staff that assist with medication delivery (staff meeting/medication training only, not through approved trainer).
6. The proper way to implement a resident ISP for staff that assist with ISPs.

B. Record review of DCS #2's training file (hire date 03/21/17), revealed no documentation that she received training in:

1. 16 hours of supervised training (shadowing) prior to providing unsupervised care.
2. Confidentiality of records and resident information.
3. Smoking policy for staff, residents and visitors.
4. Medication assistance, including the certificate of training for staff that assist with medication delivery (staff meeting/medication training only, not through approved trainer).
5. The proper way to implement a resident ISP for staff that assist with ISPs.

C. Record review of DCS #3's training file (hire date 03/01/16), revealed no documentation that she received training in:

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A 017	Continued From page 3 1. 16 hours of supervised training (shadowing) prior to providing unsupervised care. 2. Confidentiality of records and resident information. 3. Infection control 4. Smoking policy for staff, residents and visitors. 5. Medication assistance, including the certificate of training for staff that assist with medication delivery (staff meeting/medication training only, not through approved trainer). 6. The proper way to implement a resident ISP for staff that assist with ISPs. D. Record review of DCS #4's training file (hire date 08/28/15), revealed no documentation that she received training in: 1. 16 hours of supervised training (shadowing) prior to providing unsupervised care. 2. Confidentiality of records and resident information. 3. Infection control 4. Smoking policy for staff, residents and visitors. 5. Medication assistance, including the certificate of training for staff that assist with medication delivery (staff meeting/medication training only, not through approved trainer). 6. The proper way to implement a resident ISP for staff that assist with ISPs. E. Record review of DCS #5's training file (hire date 03/21/17), revealed no documentation that she received training in: 1. 16 hours of supervised training (shadowing) prior to providing unsupervised care. 2. First Aid 3. Confidentiality of records and resident information. 4. Smoking policy for staff, residents and	A 017		

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A 017	Continued From page 4	A 017		

visitors.

5. Medication assistance, including the certificate of training for staff that assist with medication delivery (staff meeting/medication training only, not through approved trainer). (Did this DCS assist with medications?)

6. The proper way to implement a resident ISP for staff that assist with ISPs.

F. Record review of DCS #6's training file (hire date 10/29/15), revealed no documentation that she received training in:

1. 16 hours of supervised training (shadowing) prior to providing unsupervised care.

2. Confidentiality of records and resident information.

3. Smoking policy for staff, residents and visitors.

4. Medication assistance, including the certificate of training for staff that assist with medication delivery (staff meeting/medication training only, not through approved trainer).

5. The proper way to implement a resident ISP for staff that assist with ISPs.

G. Record review of DCS #7's training file (hire date 07/19/14), revealed no documentation that she received training in:

1. 16 hours of supervised training (shadowing) prior to providing unsupervised care.

2. First Aid

3. Confidentiality of records and resident information.

4. Infection control.

5. Smoking policy for staff, residents and visitors

6. Emergency procedures.

7. The proper way to implement a resident ISP for staff that assist with ISPs.

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A 017	Continued From page 5 H. Record review of DCS #8's training file (hire date 09/08/17), revealed no documentation that she received training in: 1. 16 hours of supervised training (shadowing) prior to providing unsupervised care. 2. Confidentiality of records and resident information. 3. Infection control. 3. Smoking policy for staff, residents and visitors. 4. Medication assistance, including the certificate of training for staff that assist with medication delivery. (staff meeting/medication training only, not through approved trainer) 5. The proper way to implement a resident ISP for staff that assist with ISPs. I. Record review of DCS #9's training file (hire date 04/16/15), revealed no documentation that she received training in: 1. 16 hours of supervised training (shadowing) prior to providing unsupervised care. 2. First aid 3. Confidentiality of records and resident information. 3. Infection control. 4. Smoking policy for staff, residents and visitors. 5. Medication assistance, including the certificate of training for staff that assist with medication delivery (staff meeting/medication training only, not through approved trainer). 6. The proper way to implement a resident ISP for staff that assist with ISPs. J. On 01/08/18 at 2:45 pm, during an interview with the Office Manager, she confirmed that there is no documentation available for review for the above mentioned missing staff training's.	A 017		

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A 020	Continued From page 6	A 020		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (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;	A 020		

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A 020	Continued From page 7 (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require 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;	A 020		

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A 020	Continued From page 8 (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in 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	A 020		

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A 020	Continued From page 9 than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (2) (4) (8) (12) Based on record review and interview, the facility failed to ensure for 2 (R #s 2 & 4) of 15 (R #s	A 020		

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A 020	Continued From page 10 2-16) residents that: 1. The Admission/Discharge Agreements included the facilities program narrative. 2. The Admission/Discharge Agreements included the costs of services and the method of payment. 3. The Admission/Discharge Agreements included the facility's staffing ratio. 4. The Admission agreement may be terminated "if" an appropriate placement is found for the resident. These deficient practices have the potential for the residents to be at risk of: 1. Not having a written statement detailing what population is served and what services are to be provided. 2. Not knowing the costs of services and the method of payment. 3. Not knowing the facility staffing ratio. 4. Being transferred out of the facility without an appropriate place to go. The findings are: A. Record review of R #2's admission agreement dated [redacted]/17, revealed that: 1. It does not have the facility's program narrative. 2. It does not state the costs of services or the method of payment. 3. It does not state the facility's staffing ratio. 4. It does not state that the agreement can be terminated "if" an appropriate placement has been found for the resident. B. Record review of R #4's admission agreement dated [redacted]/17, revealed that: 1. It does not have the facility's program narrative.	A 020		

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A 020	Continued From page 11 2. It does not state the facility's staffing ratio. 3. It does not state that the agreement can be terminated "if" an appropriate placement has been found for the resident. C. On 01/11/18 at 3:20 pm, during an interview with the Administrator, she confirmed that the facility's admissions agreements for R #s 2 & 4 did not contain the program narrative, the facility staffing ratio, and "if an appropriate placement is found" when terminating the residents admission agreement. R #2's admission agreement did not contain the costs of services or the method of payment.	A 020		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care	A 021		

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physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission;
(5) personal and demographic information for the resident, to include:
(a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary;
(b) resident's name;
(c) age;
(d) recent photograph;
(e) marital status;
(f) date of birth;
(g) sex;
(h) address prior to admission;
(i) religion (optional);
(j) personal physician;
(k) dentist;
(l) social history;
(m) surrogate decision maker or other emergency contact person;
(n) language spoken and understood;
(o) legal documentation relevant to commitment or guardianship status;
(p) current medications list; and
(q) required diet;
(6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures;
(7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP;
(8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements

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observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility;
(9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule;
(10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided;
(11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and
(12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility.
B. Resident records maintenance.
(1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner.
(2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records.
(3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of

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A 021	Continued From page 14 request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.21 A (5) (d) B (1) Based on record review and interview, the facility failed to ensure that residents files reviewed for compliance were complete and accurate. These deficient practices could result in a delay in care or harm to all 15 (R #s 2-16) residents identified on the resident census provided by Office Manager on 01/03/18, if documents and/or important information are missing or the file is not kept in an organized manner. The findings are: A. Record review of R #s 2-16 resident files, revealed that they were not organized with a table of contents and the documents were scattered through out the file, which made documents hard to find.. B. Record review of R #s 2-16 resident files revealed that there were no pictures of the residents in their files. C. On 01/10/18 at 11:30 am, during interview with the Administrator, she confirmed that the resident files reviewed were not complete, accurate, or organized. The files were missing pictures and table of contents.	A 021		

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A 024	Continued From page 15	A 024		
A 024	7 NMAC 8.2.24 Assistance with Daily Living ASSISTANCE WITH DAILY LIVING: The facility shall supervise and assist the residents, as necessary, with health, hygiene and grooming needs, to include but not limited to the following: A. eating; B. dressing; C. oral hygiene; D. bathing; E. grooming; F. mobility; and G. toileting. [7.8.2.24 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.24 A B D Based on record review and interview the facility failed to ensure for 1 (R #1) of 1 (R #1) resident identified as requiring assistance with activities of daily living (assistance with meals, hygiene care, dressing, etc.) that he recieved his daily hygiene services and assistance with meals. This deficient practice has the potential risk of harm if residents are not receiving assistance with their activities of daily living. The findings are: A. Record review of R #1's (ISP) Individual Service Plan dated 11/01/16, revealed monitor - checks with rounds, assist with bathing dressing, grooming, encourage with meals, ambulation - low risk for falls, keep all common areas clean and free from spills and clutter. B. Record review of R #1's hospital medical	A 024		

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A 024	Continued From page 16 record dated 12/04/16 stated: family found resident laying in [redacted] bed unresponsive, not [redacted] at 2:00 pm. C. On 01/04/18 at 11:47 am, during an interview with DCS #7, she confirmed that: 1. She did not physically or verbally try to wake up R #1 for [redacted] breakfast, lunch, or assist [redacted] with bathing, changing [redacted] briefs or clothes, when she went into [redacted] room at 7:00 am and 11:00 am. 2. She did not enter resident's room again until 2:00 pm on 12/04/16 when resident's daughter inform the office that her [redacted] would not wake up. D. On 01/09/18 at 11:11 am, during an interview with DCS #6, he confirmed that: 1. He did not physically try to wake up R #1 for lunch, or assist [redacted] with bathing, changing [redacted] briefs or clothes, when [redacted] went into [redacted] room at 10:00 am and 12:00 pm on 12/04/16. 2. He did not enter residents room again until 2:00 pm on 12/04/16 when resident's [redacted] informed the office that her [redacted] would not wake up. E. On 01/11/18 at 2:30 pm, during an interview with the House Manager, she confirmed that between DCS #7 and DCS #6 they did do 2-hour checks, but did not try to wake or assist R #1 for needs/services.	A 024		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all	A 033		

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A 033	Continued From page 17 residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, 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;	A 033		

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A 033	Continued From page 18 (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any	A 033		

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A 033	Continued From page 19 state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and 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 (8) (10) (11) (d) (g) (j) Based on observation, record review and	A 033		

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A 033	Continued From page 20 interview, the facility failed to ensure the rights of all 15 (R #s 2-16) residents, as identified on the resident census list provided by the Office Manager on 01/03/18 by using full length bed rails (physical restraints) without a doctors order , free to leave and return to the facility without restrictions and by not allowing the resident or their legal representative to participate in the residents Individual Service Plan (ISP). These deficient practices can cause mental/physical harm to the residents by potential choking hazard, isolation, and by not allowing the resident to make their own heath care and social decisions. The findings are A. On 01/04/18 at 10:00 am, during observation, rooms A, C, & G were observed to have 3 residents housed in each of the rooms instead of the maximum of 2 residents allowed per room. B. On 01/04/18 at 10:15 am, during an interview with the House manager (HM), she confirmed that rooms A, C, & G had 3 residents housed in the rooms. C. On 01/03/18 at 11:36 am, during observation of R #2's room, there were bed rails on the upper portion of the bed, thus making it a choking hazard. D. On 01/03/18 at 11:40 am, during observation of R #3's room, there were bed rails on the upper portion of the bed, thus making it a choking hazard. E. On 01/03/18 at 11:45 am, during observation of R #16's room, there were bed rails on the upper portion of the bed, thus making it a choking hazard.	A 033		

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A 033	Continued From page 21 F. On 01/16/18 at 2:30 pm, during an interview with the House Manager, she confirmed that their were no doctors orders for bed rails for R #s 2, 3, & 16. Findings related to Resident's Right to come and go from facility G. On 01/03/18 at 10:30 am, during observation, it was noted that there is a keypad for entry/exit of the facility. H. On 01/03/18 at 10:30 am, during an interview with the Administrator, she confirmed that the facility is not a memory care facility, that the majority of the residents do not have the code due to safety concerns and none of the residents have a doctors order for a secure unit. Findings related to resident's right to participate in the development of ISP. I. Record review of R #s 2-16 ISP files, revealed that none of their ISPs were signed by the residents or their POA (power of attorney). K. On 01/11/18 at 2:00 pm, during an interview with the Administrator, she confirmed that none of the 6 residents had been asked to participate or sign their ISPs. 7.8.2.33 D (11) (a) Based on record review and interview the facility failed to ensure for 1 (R #1) of 1 (R #1) resident identified as requiring assistance with activities of daily living (assistance with meals, hygiene care, dressing etc.) that [redacted] recieved [redacted] daily hygiene services, assistance with meals and was found unresponsive, incontinent of bowel/bladder,	A 033		

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A 033	Continued From page 22	A 033		

requiring transport to the hospital, and died. This deficient practice has the potential risk of harm, illness and/or death if residents are not receiving assistance with their activities of daily living. The findings are:

A. Record review of R #1's (ISP) Individual Service Plan dated 11/01/16, revealed monitor - checks with rounds, assist with bathing dressing, grooming, encourage with meals, ambulation - low risk for falls, keep all common area's clean and free from spills and clutter.

B. Record review of R #1's hospital medical record dated 12/04/16 stated: family found resident laying in [redacted] bed unresponsive and [redacted] and other symptoms associated with this injury included patient found [redacted] On 1[redacted]/16 resident was admitted to inpatient hospice.

C. Record review of facility's incident report dated 12/09/16, revealed that R #1 passed away on 12/05/2016.

D. On 01/04/18 at 11:47 am, during an interview with DCS #7, she confirmed that:

1. She did not physically or verbally try to wake up R #1 for [redacted] breakfast, lunch, assistance with bathing and changing [redacted] briefs or clothes when she went into [redacted] room at 7:00 am and 11:00 am.

2. She did not enter residents room again until 2:00 pm on 12/04/16.

E. On 01/09/18 at 11:11 am, during an interview with DCS #6, he confirmed that:

1. He did not physically try to wake up R #1 for Lunch, assistance with bathing and changing [redacted] briefs or clothes at 10:00 am and 12:00 pm on

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A 033	Continued From page 23 12/04/16. 2. He did not enter residents room again until 2:00 pm on 12/04/16. F. On 01/11/18 at 2:30 pm, during an interview with the House Manager, she confirmed that between DCS #7 and DCS #6 they did do 2-hour checks, but did not try to wake or assist R #1 for needs/services or safety.	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	A 034		

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requirements for medications.
(4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name.
(5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate.
(6) The facility shall not require the residents to purchase medications from any particular pharmacy.
(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.

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A 034	Continued From page 25 (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and 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: Reference (NFPA) National Fire Protection Association 99 (Healthcare Facilities Code) 2012 Edition NFPA 99. 11.3 Cylinder and Container Storage	A 034		

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A 034	Continued From page 26 Requirements. 11.3.1* Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. 11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. 11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour 11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations. 11.3.2.8 Cylinder valve protection caps shall	A 034		

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SENIOR LIVING SYSTEMS	5 THOMAS RD BLDG I LOS LUNAS, NM 87031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 034	Continued From page 27 comply with 11.6.2.3. 11.3.2.9 Gas cylinder and liquefied gas container storage shall comply with 5.1.3.5.12. 11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 11.3.3.1 and 11.3.3.2. 11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not be required to be stored in enclosures. 11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. 11.3.3.3 When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders. 11.3.3.4 Individual small-size (A, B, D, or E) cylinders available for immediate use in patient care areas shall not be considered to be in storage. 11.3.3.5 Cylinders shall not be chained to portable or movable apparatus such as beds and oxygen tents. 11.3.4 Signs. 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following wording as a minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING 2012 Edition 7.8.2.34 A (3) (7)	A 034		

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A 034	Continued From page 28 Based on observation and interview, the facility failed to ensure that: 1. The medication refrigerator had a lock on it. 2. Extra oxygen cylinder tanks, not needed for emergency use were not being stored in resident rooms. 3. "Oxygen in Use" signs were posted outside the door of the rooms of residents who used oxygen and at the entrances of the facility. These deficient practices have the potential to cause harm, injury, or death to all 15 (R #s 2-16) residents listed on the Resident Census provided by the Office Manager on 01/03/18, if: 1. The medications are not kept in a locked refrigerator, then medications may be misused, or stolen. 2. Oxygen cylinder tanks were to fall over damaging the valve, causing it to accelerate a fire or depressurize and become tripping hazards. 3. There are no "oxygen in use" warning signs, informing residents and visitors not to smoke and/or informing firefighters that there is oxygen in the facility and in individual resident rooms during a fire. The findings are: Findings related to medication refrigerator lock A. On 01/03/18 at 10:48 am, it was observed that the medication refrigerator did not have a lock on it. B. On 01/03/18 at 10:48 am, during interview with the (HM) House Manager, she confirmed that the medication refrigerator did not have a lock on it. Findings related to oxygen storage	A 034		

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A 034	Continued From page 29 C. On 01/03/18 at 12:15 pm, during observation of room D, 3 large & 3 small oxygen cylinder tanks were observed to be stored in the corner of the room. D. On 01/03/18 at 12:15 pm, during observation, there were no 'oxygen in use" signs observed to be posted outside Room D or in the front entrance of the facility. E. On 01/03/18 at 12:15 pm, during interview with the HM, she confirmed that there were 3 large & 3 small oxygen cylinder tanks stored in room D & there were no "oxygen in use" signs posted in the facility.	A 034		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening	A 036		

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A 036	Continued From page 30	A 036		

meal and morning meal with snacks freely available;
(b) provide snacks of nourishing quality and post on the daily menu;
(c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences;
(d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle;
(e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets;
(f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room;
(g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and
(h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat.
(2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes:
(a) instruction in proper food storage;
(b) preparation and serving food;
(c) safety in food handling;
(d) appropriate personal hygiene; and
(e) infectious and communicable disease control.
B. Dietary records. The facility shall maintain the following documentation onsite:

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A 036	Continued From page 31 (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff.	A 036		

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A 036	Continued From page 32 (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in	A 036		

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A 036	Continued From page 33 the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit;	A 036		

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A 036	Continued From page 34 (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.36, D (8) (b) (c) Based on observation and interview, the facility failed to ensure that prepared foods that is transported, was maintained at proper temperatures of below 41 degrees Fahrenheit (F) or above 140 degrees F. This deficient practice could lead to foodborne illnesses that could affect all 15 (R #s 2-16) residents listed on the Resident	A 036		

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A 036	Continued From page 35 Census provided by the Office Manager on 01/03/18, if the food gets contaminated by an airborne parasite while being transported uncovered. The findings are: A. On 01/04/18 at 11:45 am, during observation of the lunch meal delivered to Building #1 by kitchen staff, it was observed being transported from the kitchen/restaurant through the outdoor courtyard, on a serving cart with the food trays uncovered and exposed to the outdoor elements. The casserole was tested as soon as it was brought into Building #1 and had a temperature of 122 degrees F. B. On 01/04/18 at 11:45 am, during interview with the House Manager, she confirmed that the transported food was not covered during transport and temperatures were not maintained at 140 degrees F or hotter.	A 036		
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease. (4) Soiled laundry shall not be stored in the	A 037		

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A 037	Continued From page 36 kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet. B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (6) (7) Based on observation and interview, the facility	A 037		

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A 037	Continued From page 37 failed to change dirty, urine soaked linens for 2 (R #s 2 & 3) of 15 (R #s 2-16) Residents. This deficient practice can cause harm to the residents by having them sleep in soiled linens. The findings are: A. On 01/03/18 at 11:42 am, during observation of R #s 3 & 7 beds, both were made up, but had a strong smell of urine coming from the sheets and blankets. When the sheets were turned back, it revealed wet stains and smelled. B. On 01/03/18 at 12:00 pm, during an interview with the (HM) House Manager, she confirmed that R #s 3 & 7 bed linens were soiled and smelled of urine.	A 037		
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored	A 038		

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A 038	Continued From page 38 in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.38 A C Based on observation and interview the facility failed to ensure that: 1. The interior of the facility was maintained in a safe and clean manner. 2. The facility was kept free of safety hazards, which includes tripping hazards, combustibles and chemicals. 3. All common areas and resident rooms were cleaned as often as necessary to maintain a clean and sanitary environment. These deficient practices have the potential for all 15 (R #s 2-16) residents, identified on the resident list provided by the Office Manager on 01/03/18, to be at risk of injury, illness, due to contamination from an unsafe and dirty environment. The findings are: A. On 01/03/18 at 11:20 am, during observation, the carpet in the hallway was torn and sticking up, creating a tripping hazard. B. On 01/03/18 at 11:30 am, during observation, the bathroom opposite room "E" had black dirt and what appeared to be mold around the base of the shower. C. On 01/03/18 at 11:42 am, during observation, R #s 3 & 7 beds were made up, but had a strong	A 038		

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A 038	Continued From page 39 smell of urine coming from the soiled sheets and blankets. D. On 01/03/18 at 11:42 am, during observation, there was a gallon of paint stored in the unlocked hallway closet. E. On 01/03/18 at 12:00 pm, during an interview with the (HM) House Manager, she confirmed that the hallway carpet had tears, that the shower had black mold and dirt, that R #s 3 & 7 bed linens were soiled with urine, and that there was a gallon of white paint stored in the unlocked hallway closed. F. On 01/08/18 at 3:35 pm, during observation of the kitchen, the cabinet under the sink had a missing door and the following chemicals and combustibles were stored there: 1. 2 cans of oven cleaner, 24 oz. 2. 1 gallon of opened Liquid dishwashing detergent 3. 1 gallon bottle of opened bleach. G. On 01/08/18 at 3:40 pm, during interview with the HM, she confirmed the missing cabinet door and cleansers stored under the sink that is easily accessible to residents with dementia (loss of memory and other mental abilities severe enough to interfere with daily life) and memory loss.	A 038		
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and	A 042		

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A 042	Continued From page 40 grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.42 B Based on observation and interview, the facility failed to ensure that the building is free from any tripping hazards. This deficient practice has the potential for all 15 (R #s 2-16) residents identified on the census provided by the Office Manager on 01/03/18, to be at risk of harm, if they were to trip over torn carpeting. The findings are: A. On 01/03/18 at 11:20 am, during observation, the carpet in the hallway was torn and sticking up creating a tripping hazard. B. On 01/03/18 at 12:00 pm, during an interview with the House Manager, she confirmed that the hallway carpet was torn and was a tripping hazard.	A 042		
A 044	7 NMAC 8.2.44 Heating, Air-Conditioning and Ventilation HEATING, AIR-CONDITIONING AND VENTILATION: A. Heating, air-conditioning, piping, boilers and	A 044		

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A 044	Continued From page 41 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 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	A 044		

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A 044	Continued From page 42 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 G Based on observation and interview, the facility failed to ensure that all operable windows and doors used for ventilation had screens on them and that they were in good repair. If the windows do not have screens that are in good condition and fit properly, then all of the 15 (R #s 2-16) residents listed on the resident census, provided by the Office Manager on 01/03/18, are at risk of harm by disease from insect infestation if the insects gain access to resident rooms through openings of the bent or missing screens. The findings are: A. On 01/03/18 at 11:45 am, during observation of room #A, it was noted that there was not a screen on the window. B. On 01/03/18 at 11:50 am, during observation of room #G, the room did not have a window in it, it had a door. The door is not screened and therefore, it can let insects and vermin into the room. C. On 01/03/18 at 11:55 am, during observation of room #B, it was noted that there was not a screen on the window D. On 01/03/18 at 12:00 pm, during interview with the HM (House Manager), she confirmed the missing screens from rooms A & B's windows	A 044		

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A 044	Continued From page 43 and that room G does not have a window, only an unscreened door.	A 044		
A 047	7 NMAC 8.2.47 Lighting and Lighting Fixtures LIGHTING AND LIGHTING FIXTURES: A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area clearly visible. B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting. C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the residents, with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering. E. Facilities with four (4) or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service. F. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7.8.2.47 NMAC - Rp, 7.8.2.48 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.47 E Based on observation and interview, the facility	A 047		

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A 047	Continued From page 44 failed to ensure that 2 of the 5 emergency lights tested in the facility were working. This deficient practice has the potential to cause harm to all 15 (R #s 2-16) residents identified on the resident census list provided by the House Manager on 01/03/18, if there were a fire or power outage, then the residents could not safely see where they were walking because the emergency lighting would not turn on. The findings are: A. On 01/04/18 at 11:00 am, during observation, two emergency lights were observed to not turn on when tested. The two broken emergency lights were located: 1. At the un-numbered hallway where it meets like a "T". 2. At the un-numbered hallway between rooms A & B. B. On 01/04/18 at 11:15 am, during interview with Maintenance Worker, he confirmed that the emergency lights did not work/turn on when tested.	A 047		
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	A 048		

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A 048	Continued From page 45 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: 7.8.2.48 A NFPA 70 National Electric Code 210.8 Ground Fault Circuit Interrupter Protection for Personnel 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	A 048		

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A 048	Continued From page 46 create a greater hazard if power is interrupted or having a design that is not compatible with Ground Fault Circuit Interrupters (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 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. Electrical outlets within 3 feet of a water supply shall be equipped with Ground Fault Circuit Interrupters (GFCI).	A 048		

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A 048	Continued From page 47 Based on observation and interview, the facility failed to ensure: 1. That electrical outlets within 6 feet of a water supply are Ground Fault Circuit Interrupters (GFCI) outlets and that they are in proper working order. 2. All fuse and breaker boxes shall be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. This deficient practice has the potential for all 15 (R #s 2-16) Residents identified on the census provided by the Office Manager on 01/03/18, to be at risk of harm, injury, or death from electrical shock if: 1. Outlets within 6 feet of water are not protected by a GFCI circuit. 2. The Fire Alarm panel is not labled on the breaker box. The findings are: Findings related to GFCI outlets A. On 01/03/18 at 11:30 am, during observation of the bathroom across from room E next to a storage closet, it was observed to not have a GFCI outlet. B. On 01/03/18 at 11:40 am, during observation of the bathroom next to room C, it was observed to not have a GFCI outlet. C. On 01/03/18 at 12:00 pm, during an interview with the House Manager, she confirmed the missing GFCI outlets in the bathrooms. Findings related to breaker for fire panel	A 048		

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A 048	Continued From page 48 D. On 01/04/18 at 11:00 am, during observation of the electrical breaker box, the fire alarm panel was not labeled on the breaker box. E. On 01/04/18 at 11:15 am, during interview with the Maintenance Worker, he confirmed that the bathrooms were missing GFCI outlets and that the electrical breaker box was missing the label for the fire panel.	A 048		
A 054	7 NMAC 8.2.54 Resident Rooms RESIDENT ROOMS: A. The facility ' s bed capacity shall not exceed the capacity approved by the licensing authority. B. Each resident room shall have an outside room with a window. The area of the outdoor window shall be at least one tenth (1/10th) of the floor area of the room. C. Resident rooms shall not be less than seven (7) feet wide in any horizontal dimension. D. There must be no through traffic in resident rooms. Resident rooms must connect directly to other internal common areas of the facility. E. The window shades, drapes, curtains, or blinds in the resident rooms shall be in good repair and of flame-retardant materials. F. Resident rooms may be private or semi-private. Semi-private rooms may not house more than two (2) residents. (1) Private rooms shall have a minimum of one hundred (100) square feet of floor area. The closet and locker area shall not be counted as part of the available floor space. (2) Semi-private rooms shall have a minimum of eighty (80) square feet of floor area for each bed and shall be furnished in such a manner that the room is not crowded and passage out of the	A 054		

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A 054	Continued From page 49	A 054		

room is not obstructed. A separate closet for each resident shall be provided. The closet and locker area shall not be counted as part of the available floor space. The beds shall be spaced at least three (3) feet apart.
G. If a resident chooses not to bring their own furnishings to the facility; each resident room shall be provided with, as a minimum, the following furnishings per resident:
(1) a bed that shall be at least thirty-six (36) inches wide, of sturdy construction and in good repair;
(2) each bed shall be provided with a clean, comfortable mattress of at least four (4) inches in thickness, which is waterproof, or protected with a waterproof covering and a mattress pad;
(3) each bed shall be provided with a clean, comfortable pillow;
(4) each bed shall be provided with a pillow case, two (2) clean sheets, blankets and a bedspread appropriate for the weather and the climate;
(5) an individual closet or closet area with a clothes rack for hanging clothes and shelves or drawers that are accessible to the resident;
(6) a dresser with drawers;
(7) a bedside table or desk;
(8) a chair;
(9) a reading lamp; and
(10) a mirror.
[7.8.2.54 NMAC - Rp, 7.8.2.55 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.54 B E F

Based on observation and interview, the facility failed to ensure that the widows had shades, drapes, curtains, or blinds, and that semi-private

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A 054	Continued From page 50 rooms housed no more then 2 residents per room. These deficient practices can cause harm to all 15 (R #s 2-16) residents identified on the resident census list provided by the Office Manager on 01/03/18, by not allowing significant privacy to each resident. The finding are: A. On 01/03/18 at 11:45 am, during observation of room #A, the blinds were broken, and the window was oval shaped at the top and the blinds did not fully cover the window. B. On 01/03/18 at 11:50 am, during observation of room #B, the blinds were broken, and the window was oval shaped at the top and the blinds did not fully cover the window. C. On 01/03/18 at 12:00 pm, during an interview with the HM (House Manager), she confirmed that rooms A & B had broken blinds and did not have window coverings long enough to cover the entire window. D. On 01/03/18 at 12:01, during observation room G does not have a window, only an unscreened door. The glass door has a sheet covering it for privacy, but it does not have a screen for ventilation. E. On 01/04/18 at 10:00 am, during observation, rooms A, C, & G were observed to have 3 residents housed in each of the rooms instead of the maximum of 2 residents allowed per room. F. On 01/04/18 at 10:15 am, during an interview with the HM, she confirmed that rooms A, C, & G had 3 residents housed in the rooms and that room G does not have a window.	A 054		

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A 059	Continued From page 51	A 059		
A 059	7 NMAC 8.2.59 Windows WINDOWS: A. Each sleeping room shall be provided with an exterior window. (1) The window shall be operable, screened and have a clear operable area of 5.7 square feet minimum; measured twenty (20) inches wide minimum and measured twenty-four (24) inches high minimum. (2) The top of the window sill shall not be more than forty-four (44) inches above the finished floor. B. Screens shall be provided on all operable windows. C. The proposed use of bars, grilles, grates or similar devices shall be reviewed and approved by the licensing authority prior to installation. D. Sleeping rooms, living rooms, activity room areas and dining room areas shall have a window area of at least one tenth (1/10) of the floor area with a minimum of ten (10) square feet. [7.8.2.59 NMAC - Rp, 7.8.2.52 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.59 A (1) B Based on observation and interview, the facility failed to ensure that all operable windows have screens on them and that they are in good repair. If the windows do not have screens that are in good condition and fit properly, then all of the 15 (R #s 2-16) residents listed on the resident census, provided by the Office Manager on 01/03/18, are at risk of harm from insect infestation if the insects gain access to resident rooms through openings of missing screens. The	A 059		

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A 059	Continued From page 52 findings are: A. On 01/03/18 at 11:45 am, during observation of room A, it was noted that there was not a screen on the window. B. On 01/03/18 at 11:45 am, during observation of room B, it was noted that there was not a screen on the window C. On 01/03/18 at 11:50 am, during observation, room G was observed to not have a window in it, only a door without a screen for ventilation. D. On 01/03/18 at 12:00 pm, during an interview with the House Manager, she confirmed that room G does not have a window and rooms A & B did not have screens on them.	A 059		
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	A 061		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5399	A. BUILDING: _____ B. WING _____	C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR LIVING SYSTEMS	5 THOMAS RD BLDG I LOS LUNAS, NM 87031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 061	Continued From page 53 shall provide detectors in common living areas and in each sleeping room. (3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service. [7.8.2.61 NMAC - Rp, 7.8.2.60 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.61 B (2) Based on observation and interview the facility failed to ensure that a working smoke detector was installed in each sleeping room/bedroom. This deficient practice has the potential for all 15 (R #s 2-16) residents identified on the resident census provided by the Office Manager on 01/03/18, to be at risk of harm and/or death if the residents do not have a smoke detector installed in their rooms to warn them of smoke/fire. The findings are: A. On 01/03/18 at 11:36 am, during an observation of the facility, it was observed that the smoke detectors in bedroom #s C, E & F, did not work/operate when tested. B. On 01/03/18 at 12:00 pm, during interview with the House Manager, she confirmed that there were no working smoke detectors in bedroom #s C, E, & F.	A 061		
A 064	7 NMAC 8.2.64 Fire Safety Equivalency System Rating	A 064		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5399	A. BUILDING: _____ B. WING _____	C 01/16/2018

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A 064	Continued From page 54 FIRE SAFETY EQUIVALENCY SYSTEM RATING: In facilities without a sprinkler system; the fire safety equivalency system shall be conducted at least annually. The facility shall maintain an evacuation rating score of prompt when a fire safety equivalency system is required. [7.8.2.64 NMAC - Rp, 7.8.2.19 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.64 Based on record review and interview, the facility failed to ensure that a Fire Safety Evacuation Score (FSES) of prompt was maintained at all times, since the facility does not have a fire protection sprinkler system. This deficient practice has the potential for all 15 (R #s 2-16) residents identified on the resident census provided by the Office Manager on 01/03/18, to be at risk of harm, injury, or death if there are not enough Direct Care Staff (DCS) on duty and/or immediately available to assist residents in evacuating the facility if a fire or other emergency that requires evacuation were to occur. The findings are: A. Record review of the facility's FSES scores dated 01/04/18 revealed a score of "slow" instead of "prompt" as required for facilities that do not have a fire prevention sprinkler system. The FSES were incorrectly scored on all 15 resident FSES forms. In addition the score indicated that the facility did not have enough DCS on duty and/or immediately available to assist residents in evacuating the facility if a fire or other emergency that requires evacuation were to occur.	A 064		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5399	A. BUILDING: _____ B. WING _____	C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 064	Continued From page 55 B. On 01/10/18 at 11:30 am, during interview with the Administrator, she confirmed that the facility's FSES score was slow and that she did not have enough DCS on duty and/or immediately available to maintain a FSES score of "prompt" as required for facilities without a fire prevention sprinkler system.	A 064		