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	2274	A. BUILDING: _____ B. WING _____	C 05/20/2022

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A 000	Initial Comments The following deficiencies were cited during an onsite and Complaint survey completed on 05/20/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake NM#53865 was substantiated with deficiencies cited	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC.	A 016		

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

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A 016	Continued From page 2 This REQUIREMENT is not met as evidenced by: 7.8.2.16. B (3) 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	A 016		

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

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A 016	Continued From page 4 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] Based on record review and interview, the facility failed to ensure that the Direct Care Staff, (DCS) received clearances from the Employee Abuse Registry (EAR) prior to their hire dates. This deficient practice could likely have a negative affect on the safety and welfare of the 9 (R #s 1-9) residents identified on the census provided by House Manager on 05/18/22, if residents are being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents. The findings are: A. Record review of DCS #1's employee file (hire date 03/10/22), revealed that the EAR clearance was not completed until 03/27/22. B. On 05/20/22 at 2:00 pm, during an interview with the Administrator, she confirmed that the EAR clearance for DCS #1 was not completed prior to hire.	A 016	DCS #1 did not show a history of abuse, neglect, or exploitation DCS #1 received a clearance letter dated March 29, 2022. This process will be monitored closely by the house manager and the Administrator. The process will be monitored with the timeliness of the DOH CCHSP response and the onboarding process The onboarding process was started with a hire date of March 10, 2022. The hiring process was halted due to the EAR process not having been started. All employees will not be onboarded prior to the CCHSP process. This process will be monitored by the Administrator until the House Manager is given credentials to enter a new hire into the database. Documentation is the printed clearances and clearance letters received from NMDOH CCHSP. The documentation is kept in an employee binder inside a locked cabinet in the home's office	
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	A 017		

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A 017	Continued From page 5 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, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 ABC	A 017		

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A 017	Continued From page 6 Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS): 1. Received 16 hours of supervised training prior to providing unsupervised care. 2. Received 12 hours of orientation training. 3. There was documentation of completion onsite at the facility and available for review. This deficient practice could likely result in the 9 (R #s 1-9) residents listed on the resident census, provided by the Administrator on 05/18/22, to be at risk of harm if they are providing care and services by DCS who have not received the required supervised and orientation trainings. The findings are. A. Record review of DCS #1's (hire date 03/10/22) training files revealed, no documentation of completing the following required trainings: 1. 16-hrs of supervised training, prior to providing unsupervised care for residents. 2. 12 hours of orientation (onboard) training. B. Record review of DCS #2's (hire date 07/01/21) training files revealed, no documentation of completing the following required trainings: 1. 16-hrs of supervised training, prior to providing unsupervised care for residents. 2. 12 hours of orientation (onboard) training. C. On 05/20/22 at 2:00 pm, during an interview with the Administrator, she stated that DCS #'s 1-2 did not have any clear documentation stating that they completed the required 16-hrs of supervised training and 12-hrs of orientation, prior to providing unsupervised care.	A 017	A017 NMAC 8.2..17 Staff training Staff Training DCS #1 and DCS #2 have completed the training. Documentation of the training is placed inside the Employee (DCS 1 & 2) All staff are completing the 16-hour in-services that are required annually. New Hires complete the 12 hours of orientation on-hire New Hires complete the 16 hours of supervised training during the first week of employment. The process will be monitored by the site House Manager	7-1-2022

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A 027	7 NMAC 8.2.27 Resident Activities RESIDENT ACTIVITIES: Each facility shall provide or make available recreational and social activities appropriate to the residents ' abilities that meet their psychosocial needs and are relevant to their social history; including a balance of cognitive, reminiscence, physical and social activities. The facility shall post the activities and encourage residents to participate. [7.8.2.27 NMAC - Rp, 7.8.2.28 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.27 Based on observation and interview the facility failed to ensure that a resident activities calendar that meet the resident's needs was posted so resident, families, and visitors would know which activities were available. This deficient practice could likely affect the mental and social well-being of the 9 (R #s 1-9) residents identified on the census, provided by the Manager on 05/18/22, if the residents are not aware of what activities are available. The findings are: A. On 05/18/22 at 10:15 am, during observation of the facility, no Activity Calendar (calendar of scheduled activities) was observed to be posted. B. On 05/18/22 at 11:20 am, during an interview with the Administrator, she confirmed that they did not have a resident Activities Calendar posted. C. On 05/18/22 at 12:15 pm, during an interview with the Administrator, she confirmed that the	A 027	7.8.2.27 The activity calendar is posted in the common area and was posted on this day. Responsibility to maintain and update the calendar will be completed and maintained by the house manager.	6-1-2022

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A 027	Continued From page 8 facility does offer activities and that currently they just did not have an Activity Calendar posted.	A 027		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010]	A 032		

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A 032	Continued From page 9 This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement), medication error which causes or is likely to cause harm, failure to follow a doctor 's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation . B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division ' s incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form.	A 032		

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A 032	Continued From page 10 Based on record review and interview, the facility failed to ensure for 2 (R #s 1 & 2) of 4 (R #s 1-4) residents whose Internal Incident Reports were reviewed for compliance, that incidents of possible abuse, neglect, or exploitation, were reported to the Licensing Authority within 24 hours or the next business day, if it is a weekend or a holiday. This deficient practice could likely result in the residents to be at risk of harm, injury, and/or death, if incidents occur and there is no oversight by the Licensing Authority. The findings are: A. Record review of R #1's Internal Incident Report dated 05/14/22, revealed the following: [redacted] 4. There was no documentation that the incident was reported to the Licensing Authority B. Record review of R #2's Internal Incident Report dated 08/14/21, revealed the following: [redacted] 3. R#2 was transported by emergency medical service (EMS) 3. There was no documentation that the incident was reported to the Licensing Authority C. On 05/19/22 at 9:20 am, during an interview	A 032	7.1.13.7 W. & 8 B. (2) (a.) (A) This incident was not reported to the licensing authority. All subsequent falls that are unwitnessed and with injury will be reported. There was no allegation or accusation of abuse, neglect, or exploitation. Note: This particular resident has a diagnosis that is contributory to falling, This resident was also a hospice patient. (B) This incident was not reported to the licensing Authority. The POA transported the resident to the emergency room. The staff was advised to call 911 by nursing.	

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A 032	Continued From page 11 with the Administrator, she confirmed: 1. R #1 [redacted] 1. The R#2 was sent out from the facility for medical treatment. 2. The incidents listed above were not reported to the Licensing Authority within 24 hours or the next business day if it was a holiday or weekend.	A 032	All falls unwitnessed or with injury will be monitored by the house manager and administrator, and reported within 24 hours or the next business day if it was a holiday or weekend. 7.1.13.7.W.8.B. (2) Effective immediately all unwitnessed falls will be reported to the licensing authority All suspected incidences of abuse & neglect will be completed by the House Manager as well as the 5 day follow-up.	6/1/2022
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 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;	A 036		

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A 036	Continued From page 12 (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: (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	A 036		

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BEEHIVE HOMES OF CLOVIS	2305 NORTH NORRIS CLOVIS, NM 88101

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A 036	Continued From page 13 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. (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	A 036		

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A 036	Continued From page 14	A 036		

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 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

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A 036	Continued From page 15 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; (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.	A 036		

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A 036	Continued From page 16 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 A (2) D (3) Based on record review, observation, and interview, the facility failed to ensure, that: 1. Food stored in refrigerators and freezers were covered, dated, and labeled and any unused leftover foods were discarded after three (3) calendar days. 2. Expired food stored in refrigerators was discarded. 3. Staff had received in service training. These deficient practices could likely result in the 9 (R #s 1-9) residents listed on the census provided by the Administrator on 05/18/22, to be at risk of contracting foodborne illnesses if:	A 036		

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A 036	Continued From page 17 1. The food, was not stored properly (dated, labeled), and leftovers were kept longer than (3) three days after being served the 1st time. 2. Expired food could be contaminated with bacteria and germs and could cause harm or death to residents. 3. Food that were not being stored at the correct temperatures, could become contaminated with bacteria and germs if they are not being monitored and recorded daily. The findings are: Findings related to the refrigerators in the kitchen and food B. On 05/19/22 at 9:03 am, during an observation of the interior kitchen refrigerator, the following was observed: 1. (1) 4.115 (pound) pork meat, expiration date 05/17/22 2. (1) pack of lunch makers, dated 12/22/21 3. (1) bag of celery, undated/unlabeled 4. (1) Ziploc bag of bacon, dated 04/27/22 5. (1) 16 ounce (oz) bag of carrot chips, not dated or labeled 6. (1) half pint carton of heavy whipping cream, Expiration date 05/17/22 7. (1) plastic container of strawberries, not dated or labeled 8. (1) one bag of bacon dated 04/27/22 Findings related to the freezer C. On 05/19/22 at 9:45 am, during an observation of the freezer, the following was observed: 1. (1) 4 ounce bag of mixed vegetable,	A 036	7.8.36 A (2) (3) 1 (1) 4.115) pound pork meat, the expiration date with of 5/17/2022 was thrown out 2 (1) Lunchmakers were brought by staff for their own lunch this day - removed from the refrigerator 3. (1) celery was thrown out 4 (1) bacon was thrown out 5 (1) 16 oz bag of carrots brought by staff for their this own lunch - removed from the refrigerator 6 (1) 1/2 pint of heavy whipping cream was thrown out 7. (1) plastic container of strawberries was thrown out 8. (1) one bag of bacon thrown out	5/19/2022

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A 036	Continued From page 18 opened and undated. 2. (1) large bag of ribs, opened and undated D. On 05/20/22 at 10:00 am, during an interview, Administrator she confirmed that the: 1. Food items in the refrigerator were expired; not labeled, sealed/covered or dated 2. Food items in the freezer were not labeled, sealed/covered or dated. 3. One (1) package of pork meat were expired. 4. One (1) half pint carton of heavy whipping cream was expired.	A 036	continued from pate 19 7.8.2.4 6A (2) D (3) all items were thrown out from both the refrigerator & freezer D on observation (5/19/2022) #'s 1,2,3, 4 were found to be in the state described and removed before 5/20/2022 The plan of correction is to have every staff member that handles food review the training and be more diligent in storing. labeling and dating foods to avoid the risks of bacteria, germs and contamination The House Manager will monitor on a daily basis at the beginning and end of every shift.	5/19/2022 5/20/2022
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 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	A 037		

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A 037	Continued From page 19 shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet. B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (10) Based on observation and interview, the facility failed to ensure that poisonous or flammable substances were not stored in residential areas, food preparation areas, or food storage areas. This deficient practice could likely result in the potential for 9 (R #s 1-9) residents identified on the census provided by the Administrator on	A 037		

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A 037	Continued From page 20 05/18/22, to be at risk of harm, illness, injury, or death if residents were to spill or ingest/swallow poisonous chemicals. The findings are: A. On 05/18/22 at 9:16 am, during an observation of the laundry room, the following chemicals were observed to be unsecured and accessible to residents: 1. (1) 32 fl. oz. (fluid ounces) carpet cleaner 2. (1) pound container of disinfectant wipes 3. (1) 32 fl. oz. all purpose cleaner 4. (1) 23 fl. oz bottle of comet 5. (1) 24 oz. bleach cleaner 6. (1) 128 oz. bleach 7. (1) 32 fl. oz. all purpose cleaner/degreaser, spot remover 8. (1) 11 oz. can of sensor cleaner 9. (1) 4 fl. oz. bottle of antibacterial cleaner 10. (2) 1 quart bottle of toilet bowl cleaner 11. (1) 1 quart bottle of anti-bacterial multi-surface cleaner B. On 05/20/22 at 2:00 pm, during an interview with the administrator, she confirmed that the above listed chemicals were stored in the unsecured laundry room and accessible to residents.	A 037	7.8.2.37. (A)10) The laundry room where the referenced items are stored and secured by a keypad lock On this date and time, staff left the door unlocked to retrieve additional items to be put to wash. I explained and showed the surveyor this mechanism. This room has two entries and going forward a second door capable of being locked from the inside will be kept locked The seriousness of leaving the room unlocked was explained to all staff leading to a write-up and possible termination The house manager will monitor the doors and task anyone entering or leaving the laundry room to put the doors on lock	5/22/2022
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	A 047		

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A 047	Continued From page 21 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 failed to ensure that all emergency lights in the facility were in working order. This deficient practice could likely result in the 9 (R #s 1-9) residents identified on the census provided by the Administrator on 05/18/22 to be at risk of harm, injury, or death, if there is a power outage or other emergency requiring evacuation occurs and the residents cannot see to safely exit the building. The findings are: A. On 05/18/22 at 11:18 pm, during observation	A 047	Continued on page 23	

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A 047	Continued From page 22 and testing of the facilities emergency lights, the emergency light in the South West Hall of the facility failed to light up when tested. B. On 5/18/22 at 12:45 pm, during observation and testing of the facilities emergency lights, the emergency light in the North hall way of the facility failed to light up when tested. B. On 05/18/22 at 12:45 pm, during an interview with the Administrator she confirmed that the facilities emergency lights located in the Southwest and North hallways of the facility were not in working order.	A 047	(A) replaced (B) replaced Both fixtures were not in working order. As a result of an inspection by the State Fire Marshal, a contractor was hired to replace the fixtures. I shared this report with the surveyor Lighting testing will be done on a monthly basis	5/23/2022 5/23/2022
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (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]	A 065		

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A 065	Continued From page 23 This REQUIREMENT is not met as evidenced by: 7.8.2.65 A Based on record request and interview, the facility failed to ensure that fire drills were conducted monthly on each eight (8) hour shift (day, evening, night) per quarter. This deficient practice could likely result in the 9 (R #s 1-9) residents identified on the census list, provided by the Administrator on 05/18/22, to be at risk of harm, injury, or death if Direct Care Staff (DCS) do not know how to safely evacuate the residents from the building if a fire were to occur. The findings are: A. Record request of the facility's fire drill records revealed that there was no fire drills have been conducted since February 2022. There was no documentation showing that the facility conducted any monthly fire drills prior for four months. B. On 05/20/22 at 2:00 pm, during an interview with the Administrator, she confirmed that the facility had not conducted any fire drills since February 2022.	A 065	- Fire drills resumed on 5/25/2022 and will be conducted on a quarterly basis Fire drills will be conducted every 8-hour period Fire drills will be conducted by the house manager and kept in a binder for "fire drills"	5/25/2022
A 066	7 NMAC 8.2.66 Staff and Resident Fire and Safety Training STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff of the facility shall know the location and the proper use of fire extinguishers and the other procedures to be followed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic	A 066		

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A 066	Continued From page 24 instructions in the use of fire prevention and techniques of evacuation. B. Facility staff shall be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident admitted to the facility shall be given an orientation tour of the facility to include the location of the exits, fire extinguishers and telephones and shall be instructed in the actions to be taken in case of fire or other emergencies. D. Fire drill procedures. The facility must conduct at least one (1) fire drill each month. (1) Fire drills shall be held at different times of the day, evening and night. (2) The fire alarm system or detector system in the facility shall be used in the fire drills. During the night, the fire drill alarm may be silenced. (3) During the fire drills, emphasis shall be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall show the date and time of the drill, the number of personnel participating in the drill, any problem(s) noted during the drill and the evacuation time in total minutes. (5) The local fire department may be requested to supervise and participate in the fire drills. [7.8.2.66 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 066		

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A 066	Continued From page 25 7.8.2.66 C Based on record review and interview, the facility failed to ensure that the residents and/or their guardian/family member(s) received fire safety and evacuation orientation upon admission to the facility. This deficient practice could likely result in all 9 (R #s 1-9) residents listed on the census provided by the Director on 05/18/22, to be at risk of harm, injury, or death if a fire or other emergency were to occur because residents/family members do not know where the fire safety equipment is, the evacuation route, and/or where the exits are. The findings are: A. Record review of R #s 1-3 resident files, revealed no documentation that the resident or their guardian/family member(s) received Fire Safety and Evacuation orientation upon admission to the facility. B. On 05/20/22 at 2:00 pm, during an interview with the Administrator, she confirmed that there was no documentation that R #s 1-3 received fire safety and evacuation orientation upon admission.	A 066	7.8 66C #1 felt it was duplication and is no longer in the home #2. I will ask again, received dated 4/31/21 #3 Provided a new packed and stressed importance 7/8/2/66 C All residents and or power of attorney completing paperwork on admission is provided with the Emergency Fire/Evacuation Plan included in the admission paperwork "Resident information Packet PPG's 10, 11,12 when reviewing the paperwork received from the families the house manager will ensure that all paperwork is acknowledged and signed.	6/27/2022 6/30/2022 7/1/2022
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following	A 068		

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A 068	Continued From page 26 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 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.	A 068		

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A 068	Continued From page 27 (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 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	A 068		

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A 068	Continued From page 28 (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. (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	A 068		

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A 068	Continued From page 29	A 068		

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 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.

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A 068	Continued From page 30 E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.68 B (1) Based on record review and interview, the facility failed to ensure that Direct Care Staff (DCS) had received the required six (6) hours of palliative/hospice training including one hour specific to resident's Individual Service Plan (ISP) annually when the facility is providing care and services for hospice residents. This deficient practice could likely result in the 5 (R #s 1-5) residents identified as receiving hospice services by the Administrator on 05/18/22, to be at risk of harm or injury if the DCS do not know the proper methods of providing care	A 068	7.8.2.68. B (1) All staff will be required to complete this training. All new hires will be required to complete this training in the first week of employment. This will be monitored, collected, and placed in the employee files by the house manager. This training is inclusive of hospice/ palliative care annual training on 1-hour in-service plans for residents that are receiving hospice services.	

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A 068	Continued From page 31 and services. The findings are: A. Record review of DCS #1's employee file (date of hire 03/10/22), revealed no palliative/hospice training was completed annually. B. Record review of DCS #2's employee file (date of hire 07/01/21), revealed, no palliative/hospice training was completed annually. C. Record review of DCS #3's employee file (date of hire 06/06/21), revealed, no palliative/hospice training was completed annually. C. On 05/20/22 at 2:00 pm, during an interview with the Administrator, she confirmed that DCS #'s 1, 2, and 3 had no record of palliative/hospice annual training, readily available and onsight to review.	A 068	7.8.2.68 13 (1) All staff have been given the annual training packet to that covers Safe Food Handling Practices and completed by no later than 7/16/2022 The house manager will monitor, collect and document the completion of all paperwork DCS #'s 1, 2 & 3 have completed the training and have been placed in DCS #s 1, 2, & 3 file. 7.8.2 68 B (1) All staff will be required to complete the annual training a packet that covers hospice/palliative training All new hires will be required to complete this training in the first week of employment DCS #1, 2 & 3 have completed the training and have been placed in DCS #2 1, 22 & 3 file.	8/1//2022
A 069	7 NMAC 8.2.69 Memory Care Units MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions. The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply. (1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer ' s gets progressively worse and is fatal. (2) " Care coordination agreement requirement "	A 069		

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A 069	Continued From page 32	A 069		

means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services.
(3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain.
(4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program.
(5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit.
B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process.
(1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services.
(2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside health care provider.
C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia,

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A 069	Continued From page 33 Alzheimer ' s disease, or other pertinent information. D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria: (1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs; (2) medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. E. Assessments and reevaluations. (1) An assessment shall be completed by a registered nurse or a physician extender within fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5) days after admission. (a) The resident shall have a medical evaluation and documentation by a physician, physician's	A 069		

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A 069	Continued From page 34 assistant or a nurse practitioner within six (6) months of admission. (b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit. (c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted. (2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident ' s stay in the assisted living facility memory care unit is still appropriate. F. Documentation in the resident ' s record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record: (1) the physician ' s diagnosis for admission to a secure environment or a memory care unit; (2) the pre-admission assessment; and (3) the re-evaluation(s). G. Secured environment. (1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to:	A 069		

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A 069	Continued From page 35 (a) double alarm systems; (b) gates connected to the fire alarm; and (c) tab alarms for residents at risk for elopement. (2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents. (a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident ' s legal representative, if applicable and prior to the resident ' s admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for.	A 069		

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A 069	Continued From page 36 (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.69 C Based on record review and interview, the facility failed to ensure that Direct Care Staff (DCS) had completed the required 12 hours of Alzheimer's/Dementia training annually. This deficient practice could likely result in the 9 (R #s 1-9) residents identified as receiving Alzheimer's/dementia (diseases negatively affecting memory, behavior, and thinking) care services by the Administrator on 05/18/22, to be at risk of harm or injury if DCS do not know the proper methods of providing care and services. The findings are: A. Record review of DCS #1's employee file (date of hire 04/11/20), revealed, no record of Alzheimer/Dementia training completed annually. B. Record review of DCS #2's employee file (date of hire 04/20/18), revealed, no record of Alzheimer/Dementia training completed annually. C. Record Review of DCS #3's employee file (date of hire 06/06/21), revealed, no record of	A 069	7.8.69 C All DCS staff have completed the required annual training. This training is inclusive of Alzheimer's Dementia DCS #'s 1,2, & 3 have completed the Alzheimer's Dementia annual training. The training will be monitored and documented by the house manager All new staff will complete the training within the first week of employment.	8/1/2022

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A 069	Continued From page 37 Alzheimer/Dementia training was completed annually. C. Record review of the Administrators employee file (date of hire 07/10/17), revealed, no record of Alzheimer/Dementia training completed annually. D. On 05/20/22 at 2:00 pm, during an interview with the Administrator, she confirmed that DCS #'s 1-3, and herself had not completed the required 12 hours of Alzheimer/Dementia training annually.	A 069	Administrator, DCS 1-3 have all completed the 12 hours of alzheimer/dementia training All trainings will be monitored by the house manager and administrator	