STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5119	A. BUILDING: _____ B. WING _____	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA GUADALUPE/LITTLE SISTERS OF THE I	1900 MARK AVENUE GALLUP, NM 87301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited as a result of a [redacted] full onsite survey completed on 03/14/19 for the New Mexico requirements for Assisted Living for Adults, 7.8.2 NMAC. [redacted]	A 000		
A 016	7 NMAC 8.2.16 Staff QualificationsSTAFF 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) (7) 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 making the inquiry to the registry prior to	A 016		

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A 016	Continued From page 3 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 directed plan of correction, civil monetary penalty	A 016		

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A 016	Continued From page 4 not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: . . . D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these	A 016		

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

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A 016	Continued From page 6 the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview the facility failed to ensure that the Direct Care Staff (DCS): 1. Had been cleared by the Employee Abuse Registry (EAR) prior to hire. 2. Fingerprints for the Caregiver Criminal History Screening Program (CCHSP) were submitted within twenty (20) days from hire date. These deficient practices have the potential to affect the safety and welfare of all 33 (R #s 1-33) residents on the census provided by the Administrator on 03/12/19, by being provided care by staff who may have a previous history of neglecting, and/or exploiting residents. The findings are:	A 016	**NMAC 7.8.2.16 B (3) (7) Refer to 7.1.12** EMPLOYEE ABUSE REGISTRY Pre-employmentrequirementspursuanttdhe EAR(EmployeeAbuseRegistryandthe CCHSR(CaregiversCriminalHistory ScreeningRequirements **CORRECTIVEACTION** DSC # 1-4 employees have been cleared by (EAR/CCHSR) and copies of clearances have beenputintheirfiles. **FOLLOW-UP ACTION** 1.All employees not previously cleared by the Employee Abuse registry prior to hire have been cleared by the EAR 2.The Human Resource director and his alternate have submitted the required fingerprints to the Department and once the fingerprints have been approved, arrangements will be made for them to take the course to be approved for the CCHSR on-line registry. 3. In the meantime, any employee not previously cleared are submitting manual fingerprints for their background checks. 4. The Administrator will monitor and oversee the completion of ensuring all background checks prior to employment. This documentation will be recorded and presented at the weekly staff meetings. Documentation will be maintained in the Administrator's office.	03/14/2019

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A 016	Continued From page 7 A. Record review of DCS #s 1-4 employee files revealed no documentation that the: 1. EARs were submitted and clearances received prior to hire. 2. CCHSP applications/fingerprints were submitted and/or clearances received. B. On 03/13/19 at 9:45 am, during an interview with the Human Resources Director, he confirmed the EAR/CCHSP findings listed above for DCS #s 1-4.	A 016		
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;	A 017		

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A 017	Continued From page 8 (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 C (1-3) (a-e) (4-12) Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS) received all required supervised, orientation, and annual trainings. This deficient practice has the potential for all 33 (R #s 1-33) residents listed on the census provided by the Administrator on 03/12/19, to be at risk of harm or injury, if staff have not received training on the methods of providing care and services. The findings are: A. Record review of DCS #1's (hire date 04/28/14) staff file revealed no documentation of receiving the following training's: 1.Sixteen (16) hours of supervised training before providing unsupervised care. 2. Orientation trainings:	A 017	**NMAC 7.8.2.17 C (1-3) (a-e) (4-12)** Training and orientation for new hires and then 12 hours annually. **CORRECTIVE ACTION** 1.DSC # 1-3 employees have completed the required orientation and annual training. **05/10/2019** 2.A member of the Restaurant Accociation conducted a food handlers certification course for all direct care staff **04/30/2019** 3.All Direct Care employees have undergone annual training to include **04/30/2019** (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (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.	

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A 017	Continued From page 9 a. Safe food handling practices to include: i. Instructions in proper storage. ii. Preparation and serving of food. iii. Safety in food handling. iv. Appropriate personal hygiene. v. Infectious and communicable disease control. b. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist with ISPs 3. Twelve (12) hours of annual trainings from 04/28/15 to 04/28/17. 4. Annual trainings from 04/28/17 to 04/28/18: a. Fire safety and evacuation training b. First aid c. Safe food handling practices include: i. Instructions in proper storage. ii. Preparation and serving of food. iii. Safety in food handling. iv. Appropriate personal hygiene. v. Infectious and communicable disease control. d. Confidentiality of records and resident information. e. Infection control. f. Resident rights. g. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; h. Smoking policy for staff, residents and visitors. i. Methods to provide quality resident care. j. Emergency procedures. k. Medication assistance, including the certificate of training for staff that assist with medication delivery. l. The proper way to implement a	A 017	**FOLLOW-UP ACTION** **1. A new orientation procedure has been put in place. All new employees currently undergo an initial training orientation in compliance with the subjects consistent with NMAC 8.2.17. Documentation of the training is placed in each employees file** **2. We are currently awaiting the results from the Food Handlers Test. The HR director will monitor the test results to ensure all direct care staff receive their food handlers card and then report his findings to the Administrator.** **3. The Administrator will monitor monthly In-Service programs for completion and compliance of the required annual training. Findings will be documented and appropriate action taken. All documentation will be maintained in the Administrator's office.**	

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A 017	Continued From page 10 resident ISP for staff that assist with ISPs. B. Record review of DCS #2's (hire date 10/14/16) staff file revealed no documentation of receiving the following trainings: 1. Sixteen (16) hours of supervised training before providing supervised care. 2. Orientation trainings: a. First aid. b. Safe food handling practices to include: i. Instructions in proper storage. ii. Preparation and serving of food. iii. Safety in food handling. iv. Appropriate personal hygiene. v. Infectious and communicable disease control. c. Quality care. d. Emergency procedures. e. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist with ISPs 3. Annual trainings from 10/14/2017 to 10/14/18: a. Fire safety and evacuation training b. first aid c. safe food handling practices (for persons involved in food preparation), to include: i. Instructions in proper storage. ii. Preparation and serving of food. iii. Safety in food handling. iv. Appropriate personal hygiene. v. Infectious and communicable disease control. d. Confidentiality of records and resident information. e. Infection control. f. Resident rights. g. Reporting requirements for abuse,	A 017		

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A 017	Continued From page 11 neglect or exploitation in accordance with 7.1.13 NMAC; h. Smoking policy for staff, residents and visitors. i. Methods to provide quality resident care. j. Emergency procedures. k. The proper way to implement a resident ISP for staff that assist with ISPs. C. Record review of DCS #3's (hire date 08/14/17) staff file revealed, no documentation of receiving the following trainings: 1. Sixteen (16) hours of supervised training before providing unsupervised care. 2. Orientation trainings: a. First aid. b. Safe food handling practices to include: i. Instructions in proper storage. ii. Preparation and serving of food. iii. Safety in food handling. iv. Appropriate personal hygiene. v. Infectious and communicable disease control. c. Quality care. d. Emergency procedures. e. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist with ISPs. D. On 03/13/19 at 2:10 pm, during an interview with the Human Resources Director, he confirmed that the above trainings had not been completed by DCS #s 1-3.	A 017		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility	A 020		

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A 020	Continued From page 12 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; (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	A 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5119	A. BUILDING: _____ B. WING _____	C 03/14/2019

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A 020	Continued From page 13 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; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical	A 020		

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A 020	Continued From page 14 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) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as	A 020		

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A 020	Continued From page 15 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 (1, 3-10) (12) (a-e) (13, 14) C (1) (a-c) D (1, 2) Refer to Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED	A 020		

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A 020	Continued From page 16 LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings. B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them.	A 020	**7.8.2.20 A (1, 3-10) (12) (a-e) (13, 14) C (1) (a-c) D (1, 2)** **Admissions and Discharges** CORRECTED ACTION 1.Signed Admission/Discharge Agreements have been executed and put in the files of R #2 and 4 2.R #3 has an updated Admission/Discharge Agreement in place in her file. 3.R #5 expired on January 20, 2019 at RMCH. Unable to update Admission/ Discharge Agreements. 4.R #2 has current documentation that a team meeting has been convened and her IISP is current and in conjunction with both Hospice and the facility. 5.All residents have signed Admission/ Discharges Agreements in their files. 6.All residents have signed written authorization for staff to assist with medications forms in their medical charts. 7.Addendum to Admission/Discharge Agreements have been signed by the residents and a copy sent to each resident's POA regarding the clarification of: -Incident Management Program -Bed Transfers -Resident's Belongings after discharge/ death -Fund Refunds at time of death. -Ratio of staff to resident -The facility rules -Resifent's Rights -The parties of the agreement -Cost of services and the method of payment -Information to formulate advanced directives -A fifteen (15) day written notice of termination	05/13/2019 05/9/2019 - 04/15/2019 04/28/2019 03/31/2019 05/10/2019

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A 020	Continued From page 17 C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health." SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately. Based on record review and interview the facility failed to ensure that: 1 Admission/Discharge Agreements were accurate and included all information required by regulation NMAC 7.8.2.20 and (SB) 0335 - 2013 2. A team meeting was convened prior to admitting/retaining residents who have chosen to receive hospice services. 3. The Individual Service Plans (ISPs) included, documentation of coordination of care with the hospice provider. These deficient practices have the potential for all 33 (R #s 1-33) residents listed on the census, provided by the Administrator on 03/12/19, to be at risk of: 1. The resident's estate or responsible party suffers financial hardship by not receiving the refund that is due upon the resident's death. 2. Being provided incorrect information and the amount of notice required by the facility to terminate an Admission/Discharge Agreement and having their Admission/Discharge Agreement terminated and/or being discharged to an improper/unsafe environment. 3. Harm and not receiving the higher level of care/services needed if: a. A resident is admitted/retained needs an increased level of care/services, beyond what the facility is able to provide. b. The Direct Care Staff (DCS) are not aware of what care/services the hospice agency	A 020	FOLLOW-UP ACTION Compliance with the regulations for Admission/ Discharge Agreements will be completed by the Business Manager and the Social Service/ Admissions Coordinator. The Administrator will monitor weekly and document findings of compliance and present it at the weekly staff meetings. Documentation will be maintained in the Administrator's office.	

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A 020	Continued From page 18 will provide and what care/services they are to provide. The findings are: Findings related to Admissions/Discharge Agreement: A. Record request for R #s 2 and 4 Admission/Discharge agreements revealed there were no agreements were in the resident's files to review. B. Record review of R #s 3 and 5 Admission/Discharge agreements revealed, they did not include the following information: 1. The parties to the agreement. 2. The facility rules, 3. The cost of services and the method of payment. 4. Refund policy for death, transfer, voluntary or involuntary discharge. 5. Information to formulate advance directives. 6. A written description of the legal rights of the residents translated into another language, if necessary. 7. The facility's staffing ratio. 8. Written authorization for staff to assist with medications. 9. Notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC. 10. The admission/discharge agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances: a. There shall be a fifteen (15) day written notice of termination given.	A 020		

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A 020	Continued From page 19 b. The resident fails to pay for stay at the facility. c. The facility ceases to operate. d. The residents health improves. 11. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services. 12. Facilities representing their services as specialized must disclose evidence of staff specialty training to prospective residents. C. On 03/13/19 at 8:20 am, during an interview with the Administrator, regarding Admissions Agreements not being completed and were missing some of the required information per the state regulations. Findings related to Hospice: C. Record review of R #2's resident file revealed: 1. No documentation that a team meeting was convened prior to her admission to hospice services in 11/21/17. 2. The ISP had not been updated to include coordination of care with hospice agency when the resident was admitted to hospice services in 11/21/17. D. On 03/13/19 at 8:20 am, during an interview with the Administrator, she confirmed that a team meeting was not convened and the ISP was not updated when the resident was admitted to hospice on 11/21/17.	A 020	NMAC 7.8.2.20 and (SB) 0335 - 2013 **Relating to hospice:** CORRECTIVE ACTION R #2 's resident file now includes updated coordination of care meeting notes that are part of the individual Service Plans (ISPs) and documentation of coordination of care with the hospice provider and the facility FOLLOW-UP ACTION 1.All current residents who are receiving hospice services have been monitored to assure on-going compliance and documentation. 2.A team meeting will be held 15 days prior to admission of a resident to hospice who due to their weakened condition would benefit from hospice, 3.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. 4.The ISP will be reviewed by the facility's staff and the hospice staff to assure that all DCS are aware of the services that will be provided.	04/15/2019
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days	A 025	5.The Director of Nursing or her designee will monitor monthly all residents who are receiving hospice care to assure on-going compliance and documentation. The documentation will be maintained in the Director of Nursing's office.	

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A 025	Continued From page 20 prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc.	A 025		

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A 025	Continued From page 21 D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 A B Based on record review and interview the facility failed to ensure for 4 (R#s 1-3 & 5) of 4 (R # 1-3 & 5) whose Evaluations/Assessments were reviewed for compliance, that they were: 1. Completed within fifteen days prior to admission. *2.Reviewed and updated every 6 months.* *3.Updated when a change of condition .* This deficient practice has the potential for all residents to be at risk of not receiving the appropriate care and services upon admission, or when there are changes in conditions. The findings are: A. Record review of R #1's Evaluations/Assessments revealed no	A 025	NMAC 7.8.2.25 A B Resident Evaluation CORRECTIVE ACTION 1. Residents #1-2-3 have completed Evaluation/Assessment in their medical files. 2. R #5 expired on January 20, 2019 at RMCH. FOLLOW-UP ACTION 1.All residents have a completed Evaluation/ Assessment document in their medical files. 2.A procedure is in place to assure that the Resident Evaluation will be done within 15 days of admission and every six months or when there has been a significant change in the resident's health status. 3.The DON (Director of Nursing) and/or her designee will monitor and document the Assessments on a monthly basis to assure compliance with the regulations. The documentation will be maintained in the Director of Nursing's office.	03/31/2019 -

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A 025	Continued From page 22 documentation that the: 1. Evaluation/Assessment (dated 01/20/15) was completed within 15 days prior to admission on 12/04/14. 2. The last completed Evaluation/Assessment (dated 12/30/15) in residents file was reviewed and updated every six months. B. Record review of R #2's Evaluation/Assessment (dated 11/23/17) revealed no documentation that: 1. It was completed within 15 days prior to admission on date of 11/20/17. 2. It was reviewed and updated when resident was admitted to hospice on 11/21/17. 3. the Evaluation/Assessment had been reviewed every six months. C. Record review of R #3's Evaluation/Assessment (dated 09/17/16) revealed no documentation that the Evaluation/Assessment had been reviewed and revised every six months. D. Record review of R #5's Evaluation/Assessment (dated 03/12/19) revealed no documentation that an Evaluation/ Assessment was completed: 1. Prior to admission date 07/01/13. 2. For review and updated until Evaluation dated 03/12/19. E. On 03/13/19 at 8:20 am, during an interview with the Administrator, she confirmed the findings listed above for R #s 1-3 and 5 Evaluations/Assessments.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan	A 026		

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A 026	Continued From page 23 INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC,	A 026		

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A 026	Continued From page 24 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (3) Based on record review and interview, the facility failed to ensure for 5 (R #s 1-5) of 5 (R #s 1-5) residents whose files that were reviewed for compliance: 1. Included Individual Service Plans (ISPs) with all the information required in 7 NMAC 8.2.26. 2. ISPs were reviewed/revised every 6 months. These deficient practices have the potential for residents to be at risk of harm if they do not receive the appropriate care and services by Direct Care Staff (DCS) if: 1. Changes in health status occur. 2. An ISP has never been developed. The findings are: A. Record review of R #1's ISP (dated 12/30/15) revealed no documentation that it has been revised/reviewed every six months. B. Record review of R #s 2-5 resident files revealed no documentation of ISPs available for review. C. On 03/13/19 at 8:20 am, during an interview with the Administrator, she confirmed: 1. R #1's ISP has not been revised/reviewed every six months. 2. R #s 2-5 resident files and that there were	A 026	7.8.2.26 A (3) Individual Service Plan CORRECTED ACTION 1. R #1's ISP has been updated 2. R #2-3-4 have completed ISPs in their charts. 3. R #5 expired on January 20, 2019 at RMCH FOLLOW-UP ACTION 1.All current residents have a complete and update ISP in their charts. 2. All new admissions will have a completed and updated ISP in their charts within 10 days of admission. 3. The Director of Nursing and/or her designee will monitor and document findings regarding residents charts to assure that they have complete and updated ISP. The documentation will be maintained in the Director of Nursing's office.	03/14/2019 03/30/2019 01/20/2019 04/10/2019

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A 026	Continued From page 25 no ISPs completed.	A 026	NMAC 7 NMAC 8.2.29 Transportation	
A 029	7 NMAC 8.2.29 Transportation TRANSPORTATION: The facility shall either provide transportation or assist the resident in using public transportation. A. The facility ' s motor vehicle transportation assistance program shall include the following elements: (1) resident evaluation; (2) staff training in hazardous driving conditions; (3) safe passenger transport and assistance; (4) emergency procedures and use of equipment; (5) supervised practice in the safe operation of motor vehicles, maintenance and safety record keeping; and (6) copies of employee training certificates that give evidence of successful completion of any applicable course(s) shall be kept on site in the employee files. B. To assist residents in using public transportation, the facility shall provide information on bus schedules, location of bus stops and telephone numbers of taxi cab companies. [7.8.2.29 NMAC - Rp, 7.8.2.30 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.29 A (1-6) Based on record review and interview, the facility failed to ensure that the drivers who transport residents had the required transportation training and certificates. This deficient practice has the potential to affect the health and safety of all 33	A 029	CORRECTED ACTION 1.DCS #s 5-9 employees have all completed a Driver's Training Course. Their certificates are in their individual files. 2.All employees who are drivers and transport the residents or assist the residents in using public transportation have completed a Driver's Training Course. FOLLOW-UP ACTION 1.All new employees who will transport residents or assist them with public transportation will be trained in the facility's motor vehicle transportation assistance program prior to transporting residents. 2.All employees who transport residents or assist them with public transportation will have annual training and review of all safety measures. 3.The Administrator will review the training reports and assure compliance with the regulations every month. Documentation of findings will be maintained in the Administrator's office.	05/15/2019 05/15/2019

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A 029	Continued From page 26 (R #s 1-33) residents identified on the census provided by the Administrator on 03/12/19, who are transported by the facility to be at risk of harm if Direct Care Staff (DCS) do not know how to provide the proper methods of safe transportation and assistance. The findings are: A. Record review of DCS #s 5-9 employee files revealed no documentation of transportation trainings for: 1. Resident evaluation. 2. Staff training in hazardous driving conditions. 3. Safe passenger transport and assistance. 4. Emergency procedures and use of equipment. 5. supervised practice in the safe operation of motor vehicles, maintenance and safety record keeping; and 6. Copies of employee training certificates that give evidence of successful completion of any applicable course(s) shall be kept on site in the employee files. B. On 03/14/19 at 1:40 pm, during an interview with the Human Resource Director, he confirmed that DCS #s 5-9, did not have documentation of receiving the trainings kept in the employee files.	A 029		
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	A 034		

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A 034	Continued From page 27 shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's 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	A 034		

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A 034	Continued From page 28 (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (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	A 034		

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A 034	Continued From page 29 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: National Fire and Protection Association (NFPA) 11.6.2.3 (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. Refer to 7.8.2.34 A. (7) and NFPA 11.6.2.3 (11). Based on observation and interview, the facility failed to ensure that all oxygen cylinder tanks were properly chained or in a stand or cart. This deficient practice has the potential for harm to all 33 (R #1-33) residents listed on the census provided by the Administrator on 03/12/19 if an oxygen cylinder tank were to fall over damaging the valve causing it to depressurize and become a missile. The findings are: A. On 03/13/19 at 2:18 pm, during an observation and tour of the facility, in the oxygen storage room 9 tall and 6 short oxygen cylinders tanks were observed to be unsecured and free standing. B. On 03/13/19 at 2:18 pm, during an interview,	A 034	NMAC 7.8.2.34 A. (7) and NFPA 11.6.2.3 (11). Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. CORRECTED ACTION The 9 tall and 6 short oxygen cylinders have been properly supported in a cylinder stand. FOLLOW-UP ACTION 1.All Nursing Staff have been in-serviced for the proper care of the freestanding oxygen cylinders. 2.All freestanding oxygen cylinders will be monitored on a weekly basis for proper storage and documented by the Safety Officer. The findings will be presented at the weekly staff meetings and appropriate action taken.	03/16/2019

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A 034	Continued From page 30 the Maintenance Service confirmed that there were 9 tall and 6 short oxygen cylinders tanks unsecured and free standing.	A 034		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour	A 035		

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A 035	Continued From page 31 period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV	A 035		

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A 035	Continued From page 32 drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record.	A 035		

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A 035	Continued From page 33 K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (5) Based on record review and interview, the facility failed to ensure the safety and welfare of 4 (R #s 2-5) of 4 (R #s 2-5) residents whose Medication Administration Records (MARs) were reviewed for compliance included both the brand and generic names of the medications. This deficient practice has the potential for all residents to be at risk of harm, injury, or death if the medications	A 035	NMAC 7.8.2.35 G (5) Medication CORRECTIVE ACTION 1.R # 2-4 MARs have been updated to include both the brand and generic names of the medications. 2.R #5 expired on January 20, 2019 at RMCH 3.All residents have had their MARs updated to include both the brand and generic names of the medications. FOLLOW-UP ACTION 1.All MARs will be monitored on a monthly basis to assure that both the brand name and the generic names of the medications are correctly on the MARs. 2.The MARs will be monitored by the Director of Nursing or her designee monthly and the findings will be documented and corrected. Documentation will be maintained in the Director of Nursing's office.	03/24/2019 - 03/30/2019

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A 035	Continued From page 34 don't have both the brand/generic names and the Direct Care Staff (DCS) who assist with medications do not know what the medication (new name) is. The findings are: A. Record review of R #2's 03/01/19 to 03/13/19 MAR revealed, it did not include both the brand/ generic names of the following medications: 1. Hydrochlorothiazide - Microzide (diuretic) 2. Lactulose - Gererlac (constipation) 3. Lisinopril - Prinivil (hypertension) 4. Artifical Tears - Polyvinyl alcohol (dry eyes) 5. Acetaminophen Rectal Suppository - Tylenol Rectal Suppository (pain) 6. Bisacodyl Rectal Suppository - Dulcolax (constipation) 7. Haloperidol - Haldol (agitation) 8. Prochlorperazine Maleate - Compro (nausea) 9. Tylenol - Acetaminophen (pain) 10. Morphine Sulfate - Roxanol (pain or shortness of breath) 11. Atropine oral suspension - Atreza (excess secretions) B. Record review of R #3's 03/01/19 to 03/13/19 revealed, it did not include both the brand/generic names of the following medications: 1. Levothyroxine - Synthroid (hypothyroidism) 2. Tylenol - Acetaminophen (pain) 3. Aripiprazole - Abilify (anxiety) 4. Oxybutin - Oxytrol (overactive bladder) 5. Act Lozenges - Act Total Care (dry mouth)	A 035		

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A 035	Continued From page 35 6. Natural Tears - Refresh Tears (dry eyes) 7. Meloxicam - Mobic (pain) 8. Buspirone - Buspar (anxiety) 9. Robitussin DM - Guaifenesin (cough) 10. Albuterol Inhaler - Ventolin Inhaler (shortness of breath) D. Record review of R #4's 03/01/19 to 03/13/19 MAR revealed, it did not include both the brand/ generic names of the following medications: 1. Senna - Sennakot (constipation) 2. Gabapentin - Neurontin (pain) 3. Ecitalopram - Lexapro (depression) 4. Celecoxib - Celebrex (pain) 5. Amlodopine - Norvasc (hypertension) 6. Occuvite - Eye vitamin (eye supplement) 7. Lidocaine Cream Gel - Aspercream (pain) 8. Lidocaine Patches - Aspercream Patches (pain) 9. Levothyroxine - Synthroid (Hypothyrodism) 10. Oxycodone - Oxycontin (pain) 11. Nerve Fix Cream - Topical pain killer (neuropathy) 12. Melatonin - Nature Made (insomnia) D. Record review of R #5's 03/01/19 to 03/13/19 MAR revealed, it did not include both the brand/ generic names of the following medications: 1. Amlodipine - Norvasc (hypertension) 2. Natural Tears - Refresh (dry eyes) 3. Timolol Solution - Timolol Maleate (glaucoma) 4. Tylenol - Acetaminophen (pain) 5. Lantus Insulin - Glargine (diabetes)	A 035		

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A 035	Continued From page 36 6. Lisinopril - Prinivil (hypertension) 7. Multivatmin - Nature's Made (supplement) 8. Latanoprost Solution - Xalatan (glaucoma) 9. Colace - Docusate (constipation) 10. Robitussin DM - Guaifenesin (Cough) E. On 03/14/19 at 9:11 am, during an interview with the Administrator, she confirmed that R #s 2-5 03/01/19 to 03/13/19 MARs did not include both the brand/generic names of the medications.	A 035		
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	A 036		

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A 036	Continued From page 37 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: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days;	A 036		

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A 036	Continued From page 38 (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. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and	A 036		

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A 036	Continued From page 39 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 the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be	A 036		

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A 036	Continued From page 40 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; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and	A 036		

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A 036	Continued From page 41 (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: National Fire and Protection Agency (NFPA) 96, "Standard for Ventilation Control and Fire Protection of Commercial Cooking Operation" The fire protection system requires annual and semi-annual inspections. Refer to 7.8.2.36 F. and NFPA 96 Based on record review and interview, the facility failed to have the cooking exhaust system inspected semi-annually. This deficient practice	A 036		

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A 036	Continued From page 42 has the potential of harm to all 33 (R #1-33) residents listed on the census provided by the Administrator on 03/12/19 and all occupants of the building should the exhaust fire protection fail in the event of a fire. The findings are: A. Record review of the cooking exhaust system inspections revealed, it was last inspected on 06/13/18. B. On 03/13/18 at 9:53 am, during an interview, MS #2 confirmed that the cooking exhaust system is only inspected once a year.	A 036	NMCA 7.8.2.36 F. and NFPA 96 Nutrition CORRECTIVE ACTION 1.The cooking exhaust system has been inspected.	05/14/2019
A 043	7 NMAC 8.2.43 Hazardous Areas HAZARDOUS AREAS: Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than one hundred (100) sq. ft., storage rooms more than fifty (50) sq. ft. but less than one hundred (100) sq. ft. not storing combustibles, storage rooms with more than one hundred (100) sq. ft. storing combustibles, chemical storage rooms with more than fifty (50) sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either: (1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter (3/4) hour rating; or (2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or (3) other hazardous areas shall be enclosed with walls with at least a twenty (20) minute fire rating	A 043	FOLLOW-UPACTION 1.Semi-annual inspections of the cooking exhaust system will be monitored and documented by the Safety Officer. 2. Documentation will be maintained in the Administrator's office.	

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A 043	Continued From page 43 and doors equivalent to one and three-quarter (1 3/4) inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. Boiler, furnace or fuel fired water heater rooms. For facilities with four (4) or more residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one (1) hour. Doors to these rooms shall be one and three-quarter (1-3/4) inch solid core. [7.8.2.43 NMAC - Rp, 7.8.2.44 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.43 A. (2) Based on observation and interview, the facility failed to ensure that the self-closing door for Mechanical Room B (hazardous area) was in working order. This deficient practice has the potential of harm and/or death for all 33 (R #1-33) residents listed on the census provided by the Administrator on 03/12/19 and all occupants the building, should there be a fire in this hazardous area. The findings are: A.On 03/13/19 at 11:10 am, during observation and tour of the facility, the self-closing door for Mechanical Room B (which houses the facility's fuel fired boilers) was observed to not close when released. B.On 03/13/19 at 11:10 am, during an interview, Maintenance Staff (MS) #2 confirmed that the Mechanical Room B door would not close when released.	A 043	NMAC 7.8.2.43 A. (2) Hazardous Areas CORRECTIVE ACTION 1.The self-closing door for Mechanical Room B has been adjusted so that it will close when released. FOLLOW-UP ACTION 1.Self-closing doors will be monitored on a weekly basis and documented by the Safety Officer. The findings will be presented at the weekly staff meeting. 2.Documentation will be maintained in the Administrator's office.	03/18/2019

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A 045	7 NMAC 8.2.45 Water WATER: Pursuant to the current New Mexico drinking water requirements, 7.6.2.9 NMAC. A. The water supply system shall be constructed, protected, operated and maintained in conformance with applicable local, state and federal laws, ordinances and regulations. B. Where a facility is supplied by its own water system, the system shall meet the sampling and construction requirement of a non-community water system as defined by the current New Mexico drinking water requirements. C. All water that is not piped into the facility directly from a public water supply system shall be from an approved source, disinfected, transported, handled, stored and dispensed in a sanitary manner. Such water shall be prevented from entering potable water systems by appropriate cross connection and backflow prevention devices. D. Hot and cold running water, under pressure shall be provided in all areas where food is prepared and where equipment and utensils are washed, sinks, lavatories, washrooms and laundries. E. The hot water temperature that is accessible to residents shall be maintained at a minimum of ninety-five (95) degrees fahrenheit and a maximum of one hundred ten (110) degrees fahrenheit. Hot water in excess of one hundred ten (110) degrees fahrenheit is permitted in kitchen and laundry areas, provided that residents are supervised in order to prevent injury. [7.8.2.45 NMAC - Rp, 7.8.2.46 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced	A 045	7 NMAC 8.2.45 Water CORRECTIVE ACTION 1.Water temperatures were adjusted to be maintained at a minimum of 95 degrees Fahrenheit and a maximum of 110 degrees in the following rooms: Resident handicap B Resident room C Sink in the south hallway for use by the residents. Resident coffee shop public restroom. FOLLOW-UP ACTION 1.Random water temperature checks will be monitored throughout the facility weekly to assure that the temperatures are maintained at a minimum temperature of 95 degrees and a maximum of 110 degrees. 2.The temperatures will be recorded by the Safety Officer and presented at the weekly staff meeting and appropriate remedial actions will be taken. 3.Documentation will be maintained in the Administrator's office.	03/15/2019

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A 045	Continued From page 45 by: Refer to 7.8.2.45 E. Based on observation and interview, the facility failed to maintain the hot water temperature at a maximum of 110 degrees Fahrenheit (F). This deficient practice has the potential for all 33 (R #1-33) residents listed on the census provided by the Administrator on 03/12/19, to be at risk of getting scalded with water that is too hot. The findings are: A. On 03/14/18 at 2:25 pm, during an observation and tour of the facility with Maintenance Staff (MS) #2, the hot water accessible to residents in the following rooms were observed: 1. Resident handicap bathroom B was 118 degrees F. 2.Resident room C was 117 degrees F. 3.Sink in the south hallway for use by residents was observed to be 112 degrees F. 4. Resident coffee shop public rest room was 114 degrees F. B. On 03/14/19 at 2:25 pm, during an interview with Maintenance Staff (MS) #2, he confirmed the temperatures listed in finding A were above 110 degrees F.	A 045		
A 050	7 NMAC 8.2.50 Exits EXITS: A. The facility shall have at least two (2) approved exits, that do not involve windows and which are remote from each other. B. Facilities with ten (10) or more residents shall have each exit clearly marked with lighted signs having letters at least six (6) inches high and at	A 050		

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A 050	Continued From page 46 least three-quarters (3/4) of an inch wide. Exit signs shall be visible at all times. C. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. D. Exits shall be clear of obstructions at all times. E. Exits, exit paths, or means of egress shall not pass through hazardous areas, garages, storerooms, closets, utility rooms, laundry rooms, bedrooms, or spaces subject to locking. F. For facilities with four (4) or more residents, sliding doors are not acceptable as a required exit. EXCEPTION: Assisted living facilities with three (3) or fewer residents may have sliding doors as required exits. G. When the yard gate(s) is part of the exit access and is locked, the gate shall be connected to the fire protection system and release upon activation of the fire/smoke system or shall have the ability to be unlocked at the gate site. [7.8.2.50 NMAC - Rp, 7.8.2.51 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.50 D. Based on observation and interview, the facility failed to keep exits clear of obstructions at all times. This deficient practice has potential to cause harm to all 33 (R #1-33) residents listed on the census provided by the Administrator on 03/12/19 and all occupants of the building should there be an emergency evacuation needed and the exits are inaccessible. The findings are: A. On 03/13/19 at 11:27 am, during an observation and tour of the facility, 6 flat bed carts	A 050		

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A 050	Continued From page 47 were blocking the exit where food deliveries are brought into the facility. B.On 03/13/19 at 11:27 am, during an interview, Maintenance Staff (MS) #2 confirmed there were 6 flat bed carts blocking the exit where food deliveries are brought into the facility. C.On 03/13/19 at 1:44 pm, during a tour of the facility there were two benches obstructing the exit corridors on the East and West side of the facility Chapel. D.On 03/13/19 at 1:44 pm, during an interview, MS #2 confirmed there were two benches obstructing the exit corridors on the East and West side of the facility Chapel.	A 050	7 NMAC 8.2.50 D Exits **CORRECTIVE ACTION** 1.The six flat bed carts were removed that were blocking the exit where food delivieries are brought into the facility. 2.The benches that were obstructing the exit corridors on the East and West sides of the Chapel were removed. **FOLLOW-UP ACTION** 1.Weekly tours of the facility will be done to assure that all exits shall be clear of obstruction at all times. 2.The findings will be recorded by the Safety Officer and presented at the weekly staff meeting and appropriate remedial actions will be taken. 3.Documentation will be maintained in the Administrator's office.	03/13/2019 03/13/2019
A 062	7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Facilities with nine (9) or more residents shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. [7.8.2.62 NMAC - Rp, 7.8.2.61 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Reference NFPA 25, 1998 Edition NFPA 25, Sect. 1-4.2 States the responsibility for properly maintaining a water-based fire protection system shall be that of the owner(s) of the	A 062		

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A 062	Continued From page 48 property. By means of periodic inspections, tests, and maintenance, the equipment shall be shown to be in good operating condition, or any defects or impairments shall be revealed. Inspection, testing, and maintenance shall be implemented in accordance with procedures meeting or exceeding those established in this document and in accordance with the manufacturer's instructions. These tasks shall be performed by personnel who have developed competence through training and experience. NFPA 25, Sect. 1-4.4 states the owner or occupant promptly shall correct or repair deficiencies, damaged parts, or impairments found while performing the inspection, test, and maintenance requirements of this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, Table 2-1 lists periodic testing and inspections required for automatic sprinkler systems. These include monthly inspection of gauges and valves on wet systems. NFPA 25, Sect. 1-8 states that records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to, valve inspections; flow, drain, and pump tests; and trip tests of dry pipe, deluge, and preaction valves. NFPA 25, Sect.1-8.1 states that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date.	A 062		

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A 062	Continued From page 49 NFPA 25, Sect.1-8.2 states that records shall be maintained by the owner. Original records shall be retained for the life of the system. Subsequent records shall be retained for a period of one year after the next inspection, test, or maintenance required by the standard. NFPA 13.6.2.7.1 Plates, escutcheons, or other devices used to cover annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. Based on observation, record review and interview the facility failed to ensure the automatic fire sprinkler system was: 1. Inspected at least quarterly in accordance with NFPA 25, (Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems.) 2. Had the sprinkler heads maintained throughout the facility. This deficient practice of not maintaining the automatic sprinkler system quarterly could result in the system being unreliable for extinguishing fire and has the potential for all 33 (R #1-33) residents listed on the census provided by the Administrator on 03/12/19, staff, and visitors to be at risk of harm, injury, or death, if a fire were to occur because the sprinkler system may not work properly. The findings are: Findings related to quarterly inspections: A.Record review of the Automatic Fire Sprinkler System inspections revealed no documented quarterly inspections. B.On 03/13/19 at 4:00 pm, during an interview,	A 062		

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A 062	Continued From page 50 the Administrator confirmed the Automatic Fire Sprinkler System was not being inspected quarterly. Findings related to sprinkler heads: C.On 03/13/19 at 2:25 pm, during an observation and tour of the facility, the escutcheons (plate covers) around the sprinkler heads were missing in resident rooms A, B and the West side activities equipment storage room. D.On 03/13/19 at 2:25 pm, in an interview, Maintenance Staff (MS #2) confirmed the escutcheons around the sprinkler heads were missing in resident rooms A, B and the West side activities equipment storage room.	A 062	7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System **CORRECTIVE ACTION** 1.The Automatic Fire Sprinkler System was inspected to comply with the regulation regarding the need to have quarterly inspections. 2.The escutcheons (plate covers) around the sprinkler heads have been replaced in Resident rooms A, B and the West side activities equipment storage rooms. **FOLLOW-UP ACTION** 1.Quarterly inspections of the Automatic Fire Sprinkler System will be scheduled with the company responsible for these quarterly inspections. 2. Escutcheons around the sprinkler heads will be monitored on a weekly basis 3.The findings will be monitored and documented by the Safety Officer and presented at the weekly staff meeting and appropriate remedial actions will be taken. 4.Documentation will be maintained in the Administrator's office.	04/10/2019 03/15/2019
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.	A 065		

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A 065	Continued From page 51 [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.65 A. B (5) Based on record review and interview, the facility failed to record the evacuation time in total minutes for the past 13 months. This deficient practice has the potential for harm and/or death for all 33 (R #1-33) residents listed on the census provided by the Administrator on 03/12/19 and all occupants of the building the evacuation time is too lengthy for an efficient and safe evacuation. The findings are: A.Record review of the monthly fire drills revealed no evacuation times were recorded for February 2018 to February 2019. B.On 03/14/19 at 3:00 pm, during an interview, the Administrator confirmed that the evacuation times were not recorded for February 2018 to February 2019.	A 065	NMAC 7.8.2.65 A. B (5) Fire Drills **CORRECTIVE ACTION** 1.The evacuation time in total minutes was recorded on the April 25th, 2019 Fire Drill report. **FOLLOW-UP ACTION** 1.All Fire Drills will record the evaluation time in total minutes on the report. 2.The Maintenance Supervisor will monitor the monthly Fire Drills to assure that the evacuation time in total minutes has been recorded on the report. 3.Documentation will be maintained in the Administrator's office.	04/25/2019
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health,	A 070		

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A 070	Continued From page 52 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.70 D, E Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the	A 070		

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A 070	Continued From page 53 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 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	A 070		

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A 070	Continued From page 54 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 directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: . . . D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved	A 070		

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A 070	Continued From page 55 media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. . . . E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal	A 070		

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A 070	Continued From page 56 Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview the facility failed to ensure that the Direct Care Staff (DCS):	A 070		

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A 070	Continued From page 57 1. Had been cleared by the Employee Abuse Registry (EAR) prior to hire. 2. Fingerprints for the Caregiver Criminal History Screening Program (CCHSP) were submitted within twenty (20) days from hire date. These deficient practices have the potential to affect the safety and welfare of all 33 (R #s 1-33) residents on the census provided by the Administrator on 03/12/19, by 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 #s 1-4 employee files revealed no documentation that the: 1. EARs were submitted and clearances received prior to hire. 2. CCHSP applications/fingerprints were submitted and/or clearances received. B. On 03/13/19 at 9:45 am, during an interview with the Human Resources Director, he confirmed the EAR/CCHSP findings listed above for DCS #s 1-4.	A 070	NMAC 7.8.2.70 D, E Pre-employment requirements pursuant to the EAR (Employee Abuse Registry and the CCHSR (Caregivers Criminal History Screening Requirements **CORRECTIVE ACTION** 1.DSC # 1-4 employees have been cleared by (EAR/CCHSP) and copies of clearances have been placed in their files. **FOLLOW-UP ACTION** 1.All employees not previously cleared by the Employee Abuse registry prior to hire have been cleared by the EAR 2.The Human Resource Director and his alternate have submitted the required fingerprints to the Department and once the fingerprints have been approved, arrangements will be made for them to take the course to be approved for the CCHSR on-line registry. 3.In the meantime, any employee not previously cleared are submitting manual fingerprints for their background checks. 4.The Administrator will monitor and oversee the completion of ensuring all background checks prior to employment. This documentation will be recorded and presented at the weekly staff meetings. Documentation will be maintained in the Administrator's office.	03/14/2019