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	5831	A. BUILDING: _____ B. WING _____	C 11/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWIND HOUSE	6600 LOS VOLCANES NW ALBUQUERQUE, NM 87121

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A 000	Initial Comments The following deficiencies were cited during a Full-Onsite/Complaint survey completed on 11/19/18 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint NM#33289 was substantiated with deficiencies cited. A Class A Deficiency was called.	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements	A 016		

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

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A 016	Continued From page 2 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.16 B (3) (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.	A 016		

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A 016	Continued From page 3 C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The 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	A 016		

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A 016	Continued From page 4	A 016		

the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.
[7.1.12.8 NMAC - N, 01/01/2006]

7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:
. . .

D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department.
(1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC.

(2) A signed authorization for release of information form.
(3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink.
(4) The fee specified by the department for the 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

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A 016	Continued From page 5 cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. . . . E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. 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)	A 016		

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A 016	Continued From page 6	A 016		

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 3 (RCC and DCS #s 2 &3) of 4 (RCC and DCS #s 1-3) Resident Care Coordinator and Direct Care Staff:

1. Were cleared by the Employee Abuse Registry prior to hire.

2. Applications and fingerprints for the Caregiver Criminal History Screening program (CCHSP) were submitted within twenty (20) days from date of hire.

These deficient practices have the potential to affect the safety and welfare of all residents, being provided care by staff who may have a

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A 016	Continued From page 7 previous history of abusing, neglecting, and/or exploiting residents. The findings are: A. Record review of Resident Care Coordinator's (RCC) employee file hire date 03/05/17 revealed that the EAR application was not submitted/clearance received until 04/12/17, and the CCHP application and fingerprints were not submitted until 04/20/17, B. Record review of DCS #2's employee file hire date 10/10/16 revealed that the EAR application was not submitted/clearance received until 10/18/16, C. Record review of DCS #3's employee file hire date 05/30/18 revealed that the EAR applications (2) were not submitted/clearance received until 06/21/18 & 07/20/18. D. On 11/18/18 at 9:00 am, during an interview with the Administrator, she confirmed the EAR and CCHSP findings for the RCC and DCS #s 2 & 3.	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:	A 017		

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A 017	Continued From page 8 (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 A B C (2) (3) (9) (12) Based on record review and interview, the facility failed to ensure for 4 (RCC and DCS 's 1-3) of 4 (RCC and DCS #s 1-3) Resident Care Coordinator and Direct Care Staff whose staff	A 017		

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A 017	Continued From page 9 files were reviewed for training compliance received: 1. Sixteen (16) hours of supervised training prior to providing unsupervised care. 2. Fire Safety and Evacuation training at orientation and/or annually. This deficient practice has the potential for all residents to be at risk of harm if they are being provided care by staff who were not trained: 1. To provide care that meets each residents individual needs before providing unsupervised care. 2. On how to prevent/extinguish a fire and how to conduct a safe evacuation if a fire or other emergency were to occur. The findings are: A. Record review of the RCC and DCS #s 1-3 training files revealed, no documentation that they had received: 1. Sixteen (16) hours of supervised training prior to providing unsupervised care. 2. Fire Safety and Evacuation training at orientation and/or annually. B. On 11/15/18 at 9:00 am, during an interview with the Administrator, she confirmed that there was no documentation that the RCC and DCS #s 1-3 received the trainings listed above.	A 017		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age	A 020		

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A 020	Continued From page 10 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 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:	A 020		

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A 020	Continued From page 11 (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 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	A 020		

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isolation techniques;
(10) residents that require the use of a Hoyer lift; and
(11) ostomy (unless resident is able to provide self care).
C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements.
(1) Convene a team, comprised of:
(a) the facility administrator and a facility health care professional if desired;
(b) the resident or resident ' s surrogate decision maker; and
(c) the hospice or home health clinician.
(2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall:
(a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met;
(b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES);
(c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and
(d) include an independent advocate such as a

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A 020	Continued From page 13 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 (5) (12) (a-e) (i) (ii) (iii) C (1-2) D (1) Refer to Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW	A 020		

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	5831	A. BUILDING: _____ B. WING _____	C 11/19/2018

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A 020	Continued From page 14 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. 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.	A 020		

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A 020	Continued From page 15 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 and were available for review. 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 44 (R #s 1-44) residents listed on the census, provided by the Resident Care Coordinator on 11/06/18, 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. 3. Having their Admission/Discharge Agreement terminated and/or being discharged to an improper/unsafe environment. 4. There being no oversight by the Licensing Authority if Admission Agreements are not available for review. 5. Harm and not receiving the higher level of care/services needed if: a. A resident is admitted/retained that an increased level of care needed beyond what the facility is able to provide. b. The Direct Care Staff (DCS) are not aware of what care/services the hospice agency will provide and what care/services they are to provide. The findings are:	A 020		

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A 020	Continued From page 16 Findings related to Admission/Discharge Agreements A. Record review of R #s 1, 3 & 4's admission discharge agreements revealed the following missing/incorrect information: 1. Refund policy for death, transfer, voluntary or involuntary discharge. 2. The admission 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. b. Resident fails to pay. c. Facility fails to operate. d. Resident's health improves. e. Termination without prior notice for emergency situations; i. Transfer or discharge necessary for safety and welfare. ii. Resident's needs cannot safely be met by the facility. iii. Safety and health of other residents and staff are endangered. B. Record request for R #6's Resident Chart revealed there was no Admission Agreement found in the chart. C. On 11/08/18 at 11:18 am during an interview with the Administrator, she confirmed: 1. The above listed Admission/Discharge Agreement findings for R #s 1, 3 & 4. 2. R #6's Admission/Discharge Agreement was missing from the chart and stated that the chart is the only place it should be. Findings related to Hospice:	A 020		

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A 020	Continued From page 17 D. Record review of R #1's resident file revealed: 1. No documentation that a team meeting was convened prior to [redacted] admission to hospice services on [redacted]/18. 2. ISPs (dated 12/18/17 & 07/13/18) had not been updated to include coordination of care with hospice agency. E. Record review of R #2's ISPs (dated 07/11/17, 07/11/18 & 08/10/18) revealed they had not been updated to include coordination of care with hospice agency when R #2 was admitted to hospice services on [redacted]/18. F. On 11/13/18 at 2:30 pm during an interview with the Administrator, she confirmed: 1. There was no team meeting convened for R #1 prior to being admitted to hospice on [redacted]/18. 2. The ISPs for R #s 1 & 2 were not updated to include coordination of care with the hospice agency.	A 020		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status.	A 025		

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A 025	Continued From page 18 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. 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	A 025		

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A 025	Continued From page 19 significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010]	A 025		

This REQUIREMENT is not met as evidenced by:
7.8.2.25 B

Based on record review and interview, the facility failed to ensure for 5 (R #s 1-5) of 5 (R #s 1-5) residents that their evaluations had been reviewed and updated at a minimum of every six (6) months or when a change of condition occurred. This deficient practice has the potential for residents to be at risk of not receiving the appropriate/higher level of care and assistance needed as changes in their health status occur. The findings are:

A. Record review of R #1's evaluations (dated 12/18/17 and 07/13/18) revealed that the evaluations had not been reviewed and if needed updated:
1. At a minimum of every 6 months.
2. When a change of condition occurred and the resident was admitted to hospice services on 04/18/18.

B. Record review of R #2's evaluations (dated 07/11/17 and 07/11/18) revealed that the evaluations had not been reviewed and updated:
1. At a minimum of every 6 months.
2. When a change of condition occurred and the resident was admitted to hospice services on [redacted]/18.

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A 025	Continued From page 20 C. Record review of R #3's evaluations (dated 11/23/17 and 07/13/18) revealed, that the evaluations had not been reviewed and if needed updated at a minimum of every 6 months and pages 4-6 of the evaluations was missing. D. Record review of R #4's evaluations (dated 09/28/17 and 07/25/18) revealed, that the evaluations had not been reviewed and if needed updated at a minimum of every 6 months. E. Record review of R #5's evaluation (dated 10/10/17) revealed, that the evaluations had not been reviewed and if needed updated at a minimum of every 6 months. F. On 11/13/18 at 2:30 pm, during an interview with the Administrator, she confirmed that the evaluations for R #s 1-5 had not been reviewed and if needed updated at a minimum of every 6 months or when a change of condition occurred.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a	A 026		

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A 026	Continued From page 21 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, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (1) (3) Based on record review and interview the facility failed to ensure for 4 (R #s 1, 2, 4 and 5) of 4 (R #s 1, 2, 4 and 5) residents whose Individual Service Plans (ISP) were reviewed for compliance were: 1. Reviewed and/or updated at a minimum of every six (6) months or when a change in condition occurred.	A 026		

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A 026	Continued From page 22 2. Included coordination of care with the hospice agency. 3. Located in the chart and available for review. These deficient practices have the potential for residents to not receive the appropriate care/assistance needed if the Direct Care Staff (DCS) do not: 1. Have accurate, available, and current information on what care/services are needed by the residents. 2. Know what care/services they need to provide and what services the hospice agency will provide. The findings are: A. Record review of R #1's Physician's Order dated [redacted]/18, revealed that R #1 is able to keep and manage [redacted] own medications. Record review of R #1's ISPs (dated 12/18/17 & 07/13/18) revealed, that they had not been reviewed and if needed updated: 1. At a minimum of every 6 months. 2. To reflect that R #1 is able to keep and administer [redacted] own medications. 3. To include coordination of care with hospice provider when the resident was admitted to hospice services on [redacted]/18. B. Record review of R #2's ISPs (dated 07/11/17, 07/11/18 & 08/10/18) revealed they had not been reviewed and if needed updated: 1. At a minimum of every six (6) months. 2. To include coordination of care with hospice provider when the resident admitted to hospice services on [redacted]/18.	A 026		

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A 026	Continued From page 23 C. Record review of R #4's Resident Chart revealed [redacted] was admitted to the facility on [redacted]/19 and there were not documentation of any ISPs prior to 07/25/18. D. Record review of R #5's ISPs (dated 02/22/17 & 07/24/18) revealed, that they had not been reviewed and if needed updated at a minimum of every 6 months. E. On 11/13/18 at 2:30 pm, during an interview with the Administrator, she confirmed the ISP findings listed above for R #s 1, 2, 4 and 5.	A 026		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or	A 033		

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A 033	Continued From page 24 (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation;	A 033		

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A 033	Continued From page 25 (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management;	A 033		

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A 033	Continued From page 26 (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (5) (10) (11) (a) 7.8.2.7 DEFINITIONS: . . . AW. "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness and is defined in the Incident Reporting Intake, Processing & Training Requirements, 7.1.13 NMAC. 7.1.137. DEFINITIONS: . . . T. "Neglect" means the failure of the caretaker to provide basic needs of a person, such as clothing, food, shelter, supervision and care for the physical and mental health of that person. Neglect causes, or is likely to cause, harm to a person. Class A Deficiency The facility failed to ensure for 1 (R #6) resident that Emergency Medical Services (EMS) were received in an acceptable amount of time, that	A 033		

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could have decreased the resident's risk of death by failing to:

1. Contact [redacted] medical provider when R #6 first began to have [redacted]

2. Call 911 when R #6's condition continued to decline.

3. Train all Direct Care Staff (DCS) that they have the right/responsibly to call 911 when needed, without fear of retaliation.

A Class A deficiency was called on 11/13/18 at 4:28 pm, the Administrator was informed at this time, and a Plan of Removal (POR) was requested.

On 11/19/18 at at 1:25 pm, the following POR was received:

1. Effective immediately, all caregivers are reminded that they can call 911 free of retaliation in the event of acute illness, injury, or rapid decline in condition.

2. Residents Hospice/Service Providers will be contacted immediately after the initial event. If the agency does not respond after 5 minutes (by phone) to assess the resident's condition, give instructions to caregivers, and the resident's condition is life threatening, examples:

a. Chest pain.
b. Injuries.
c. Seizures.
d. Bleeding.
e. Choking.
f. Loss of consciousness.
g. Breathing issues, etc, caregiver must call 911 and the resident's condition will be assessed by emergency medical services and if needed sent out to the hospital.

3. In conjunction with facility's Registered Nurse (RN) Consultant, the Director will conduct training for the Resident Care Coordinator (RCC)

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and all staff covering company policies and Assisted Living Facility Regulations regarding the handling of medical emergencies.

4. A mandatory first aid and CPR (cardiopulmonary resuscitation) training was scheduled and completed on 11/16/18.

5. The protocol for handling emergencies will be posted on the bulletin board in the break room.

6. The facility will schedule CPR training within the month for employees who did not take the class on 11/16/18. CPR will be reviewed as required.

7. An inservice will be held to review the facility's Policy and Procedure and signed by each DCS member within 1 week.

8. Going forward these trainings will be included in orientation and annual training. "

The Administrator was informed that the Class-A deficiency was accepted and lifted.

Based on record review, observation, and interview, the facility failed to ensure for 1 (R #6) of 1 (R #6) resident who died after having a life-threatening medical event:

1. Received medical assessments and emergency medical services (EMS) when needed.

2. Hospice/Service provider agencies were contacted immediately when a medical event occurred, not wait until the after the medical event was over.

3. Oxygen was not discontinued prior to Emergency Medical Services (EMS) arrival.

4. Were being assessed and cared for by DCS who knew their rights/responsibility to call 911.

These deficient practices have the potential for residents to be at risk of illness, injury, and death if:

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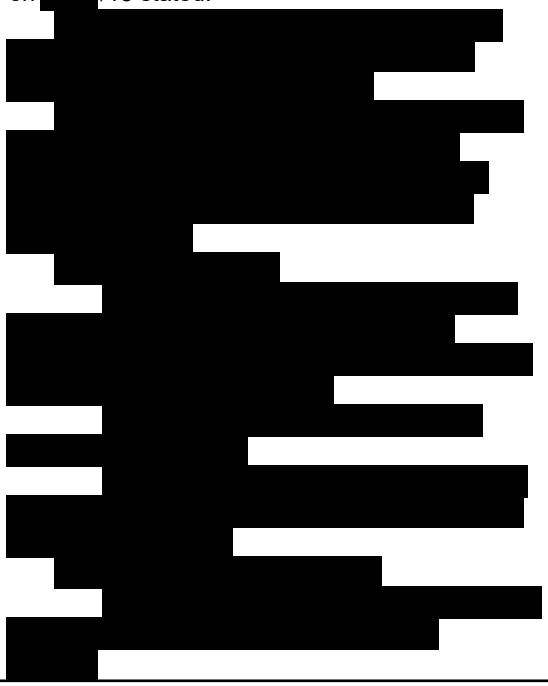
A 033	Continued From page 29 1. Residents are not assessed by qualified medical personnel (Licensed Nurse, Paramedics, Doctors, etc.) immediately when having a life-threatening medical event. 2. Hospice/Service provider agencies are not contacted, therefore unable to provide medical assessments and instructions to the DCS. 3. Oxygen treatments are discontinued by non-qualified DCS, reducing possible resuscitation by EMS. 4. If 911 is not called, because the the Resident Care Coordinator (RCC) made the decision that it was not necessary. The findings are: A. Record review of a complaint intake received on [redacted]/18 stated: 	A 033		

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A 033	Continued From page 30 b. Based on the R #6's presentation and ultimate death and reports from DCS, the complainant feels that at least two (2) DCS (names unknown) were neglectful in caring for R #6. B. On 11/07/18 at 11:15 am, during an interview with the Ombudsman Volunteer (OV), she stated that: 1. She was informed by anonymous resident (AR) that the cause of death for R #6 was [redacted] 2. On 11/05/18, OV met with AR regarding the incident and death of R #6 who told her the following information: a. R #6 had no family or POA/Guardian. b. R #6 cried for help, but based on [redacted] previous refusals earlier in the day the RCC did not call 911 prior to R #6's [redacted] c. AR stated she had a meeting (date/time-unknown) with RCC and 2 DCS that assist with medications. AR told OV, that RCC admitted that she did not call the ambulance sooner, based on R #6's previous refusals and stated that after R #6's [redacted] the RCC was very upset and went to church/confession and that the trust factor for the RCC is gone. 3. OV stated that DCS #1 was with R #6 when [redacted] and she does not know of any other incidents like this ever happening before. C. On 11/06/18 at 12:20 pm, during an interview with the Administrator, she stated that she was here the day of the incident, but did not arrive until the paramedics had arrived. She says she has the tape for the night of the incident, that resident had a full-code status and provided the name and contact information for R #6's Power of Attorney (POA).	A 033		

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D. On 11/06/18 at 1:08 pm, during an interview with the RCC, she stated, that she came into the facility at 12:30 pm, on the day of the incident to cover a shift. RCC stated that she observed DCS #2 taking R #6's vitals and then took [redacted] back to [redacted] room. The RCC said that R #6 was not alert/hardly breathing when EMS arrived. RCC was asked the following questions and gave the responding answers:

1. Are you a nurse? No.
2. Are you qualified to access residents? No.
3. Was POA called? Not until after resident's death.
4. Was the resident's hospice/service provider agency called? Not until after resident's death.

RCC stated that R #6 was recently hospitalized and was on [redacted] She stated that the [redacted] was taken off of R #6 when [redacted] was assisted to the bathroom. When assisted back to bed R #6 did not want it on because it was drying [redacted] RCC confirmed that when resident was found barely breathing/non-responsive [redacted] was not put back on [redacted] RCC said to be honest, she did not even think about it.

E. On 11/07/18 at 2:45 pm, during an interview with DCS #1, she stated that at approximately ½-to 1 hr before R #6 passed, she was called to assist [redacted] to the restroom. DCS #1 said she cleaned R #6 and helped [redacted] back to bed and put [redacted] She tried to give R #6 some water, but [redacted] refused. At that time R #6 was talking, alert, and complained of pain. When she went back to check on R #6, [redacted] was still complaining of pain, then RCC came. DCS #1 stated that she stayed with R #6 until the paramedics arrived. DCS #1 said R #6 was alert when she came into the room, but then went gray and was barely breathing seconds before the paramedics arrived.

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A 033	Continued From page 32 DCS #1 stated that she took off R #6's [redacted] right before the paramedics arrived, because she could not feel a pulse in [redacted] F. Record review of R #1's service provider's Advanced Directive form dated 12/03/12 revealed that R #1's wish was to have "all measures taken to revive and resuscitate. G. Record review of R #6's After Visit Summary from the hospital dated [redacted]/18 revealed that the: [redacted] H. Record review of R #1's History and Physical (H&P) form dated 02/14/18, revealed that the doctor did discuss the MOST (Medical Orders for Scope of Treatment) form that provides EMS with information regarding the residents wish for life treatments with R #1, but was not signed. I. On 11/07/18 at 4:00 pm, during an interview with the Administrator, she stated to her knowledge R #6 did not have a DNR order and the residents code status was full-code and was on O2-continuously. J. On 11/08/18 at 10:35 am during observation of the white board behind the receptionist desk, it was observed to state that "for any emergency call [name of service provider and contact number] for [name of service provider] residents". K. On 11/08/18 at 10:39 am, during an interview with the RCC, she stated that on the afternoon of 10/28/18, everything was hectic and she forgot to call the service provider, but did think about it.	A 033		

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The RCC said she knows she should have called the service provider when R #6 was first began having trouble breathing. RCC confirmed that she did not call them until after R #6 died, when the Administrator told her too. The RCC confirmed that the facility policy is to call the service provider for any emergency.

L. On 11/13/18 at 11:52 am, during an interview with the complainant, she stated that a 911 call was received regarding R #6 stating shortness of breath/barely breathing. When paramedics arrived, they found R #6 lying in the middle of the bed laying sideways with [redacted] hands by [redacted] sides. R#6 was in full cardiac arrest (heart had stopped) and based on carbon monoxide levels [redacted] had been dead for a length of time (2-3 minutes). Complainant said that when EMS arrived, there was no one in the room and no [redacted] on resident.

M. On 11/13/18 at 2:45 pm, during an interview with AR, she stated that on the day of R #6's death, [redacted] had breakfast with R #6 who seemed fine, but a little pale. R #6 did not have [redacted] on and AR asked [redacted] if [redacted] needed to put [redacted] on, [redacted] then put it on and [redacted] color returned. AR said she found out the next morning that R #6 had died. AR stated that a night DCS told her that the RCC told the DCS staff not to call 911 and gave [redacted]

N. On 11/13/18 at 3:20 pm, during review of video tape (dated 10/28/18), beginning at 12:00 pm (noon) with the Administrator revealed, that R #6 was given [redacted] medications at 2:46 pm and that EMS were not called until 3:46 pm.

O. On 11/14/18 at 8:42 am, during an interview with DCS #6, she stated, that on 10/08/18 at approximately 1:15 pm, R #6 was at the dining

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room table and gasping for air, gritting [redacted] teeth, and was not able to answer questions due to trying to breathe. DCS #6 said that R #6 did have [redacted] DCS #2 checked [redacted] and [redacted] DCS #6 told the RCC who said, "don't worry, [redacted] is just having a panic attack." DCS #6 stated that she told DCS #2 that what was happening to R #6 was not a panic attack. R #6 had been trying to eat but did not eat very much. DCS #6 stated that she started doing 1st rounds at 2:15 pm and the RCC told her that since resident was on hospice there was no need to call 911 and DCS #2 told her that if they called 911, they could get in trouble. DCS #6 stated that at 3:00 pm, when she checked on R #6, [redacted] was in the bathroom with [redacted] then went back to bed, with [redacted]

P. On 11/14/18 at 2:12 pm, during an interview with R #3 (roommate of R #6), [redacted] stated that R #6 was yelling and yelling which made R #3 feel upset so [redacted] left the room, when [redacted] came back in R #6 was still yelling so [redacted] went and got the RCC. The RCC told her that
R #6 was having a panic attack. R #3 stated that R #6 had panic attacks in the past, but nothing like this. RCC came and tried to get R #6 to breathe into a paper sack. R #3 said [redacted] saw R #6 and [redacted] (it scared R #3). R #3 stated [redacted] asked R #6 if [redacted] wanted to call an ambulance and R #6 said "yes." R #3 said that R #6's [redacted] was on and off, during all the time [redacted] was yelling "Help me" Help me" R #3 said that the memory of the incident will stay with [redacted] forever. Again, [redacted] repeated that R #6 had yelling episodes in the past, but never like this. When the paramedics arrived they came and told R #3 to stay in [redacted] room, R #3 told them [redacted] needed to go out. The RCC came and took R #3 out of the room. R #3 said that after R #6 1st

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A 033	Continued From page 35 started yelling, [redacted] never calmed down and just continued yelling. R #3 stated that the incident really scared [redacted] Q. Record review of the facility's Policy and Procedures (P&P)'s revealed it stated the following: 1. For all emergencies call 911. 2. For all resident emergencies, including not (trouble) breathing: a. First call 911, b. Second call the person in charge and family/responsible party. 3. First Aid trained staff will provide immediate care. R. On 11/15/18 at 9:15 am, during an interview with the Administrator, she confirmed that the facility policies were not followed when R #6 began having trouble breathing. S. On 11/15/18 at 10:40 am, during an interview with DCS #2, he stated that sometime between 12:30 pm and 1:30 pm (in dining room) on the day that R #6 [redacted] he was going to lunch when a DCS informed him that R #6 was not feeling well, was [redacted] DCS #2 took R #6's vitals which were all good except [redacted] was a bit low. Around 2:30 pm, R #6 began screaming and the RCC went to check on [redacted] The RCC stated that R #6 was having a panic attack and requested a [redacted] which I took and gave to the resident.	A 033		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to	A 034		

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A 034	Continued From page 36 this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's 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	A 034		

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A 034	Continued From page 37 for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall 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	A 034		

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A 034	Continued From page 38 administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (1) (5) Based on record review and interview, the facility failed to ensure that the: 1. Medication cart was locked at all times when not in use. 2. Residents who keep and manage their own medications have a physician's order stating they are capable to do so. This deficient practice has the potential of all 44 (R #s 1-44) residents listed on the census, provided by the Resident Care Coordinator on 11/06/18, of harm, illness, and/or death if: 1. The medication carts are not locked, medications are stolen, taken by the wrong resident, and/or miss medications, because they are not available. 2. If residents who are managing their own	A 034		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWIND HOUSE	6600 LOS VOLCANES NW ALBUQUERQUE, NM 87121

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A 034	Continued From page 39	A 034		

medications have not been deemed capable by their doctor and have a physicians order on file at the facility and/or take the wrong dose at the wrong time or miss needed medications.

The findings are:

Findings related to locked medication carts:

A. On 11/07/18 at 10:13 am, during an observation of Medication Cart B, it was observed to be unlocked, with no Direct Care Staff (DCS) nearby.

B. On 11/07/18 at 10:15 am, during an interview with the Resident Care Coordinator (RCC), she confirmed the observation that Medication Cart B was unlocked, with no DCS nearby.

C. On 11/08/18 at 1:16 pm, during an observation of Medication Cart B, it was observed to be unlocked, with no DCS nearby.

D. On 11/08/18 at 1:17 pm, during an interview with the RCC, she confirmed the observation that Medication Cart B was unlocked, with no DCS nearby.

Findings related to medication management:

E. Record review of R #1's evaluation dated [redacted]/17 and [redacted]/18 revealed a note at the top of the page stating that R #1 takes [redacted] own medications.

F. Record review of R #1's resident file revealed no documentation of a physician's order to manage [redacted] own medications.

G. On 11/13/18 at 2:30 pm, during an interview

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A 034	Continued From page 40 with the Administrator, she confirmed there was no physician's order for R #1 to manage [redacted] own medications.	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 41 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 42 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 43 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: 7.8.35 D G Based on observation and interview, the facility failed to ensure that: 1. Only a Licensed Nurse (LN) conduct invasive procedures such as finger sticks for residents with diabetes. 2. Medication orders were transferred to the Medication Administration Record when received.	A 035		

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A 035	Continued From page 44	A 035		

This deficient practice has the potential for all 44 (R #s 1-44) residents listed on the census, provided by the Resident Care Coordinator on 11/06/18, to be at risk of illness, injury, harm, or death if:

1. Unlicensed/non-qualified Direct Care Staff (DCS) incorrectly perform invasive procedures (blood sugar checks) that could cause harm or injury if done incorrectly causing excessive bleeding and/or infection if exposed to bacteria/germs.

2. Needed medications are received/not received because there is not documentation/instructions on the MAR for the DCS to follow.

The findings are:

Findings related to finger sticks:

A. On 11/08/18 at 8:32 am, during observation of a med-pass by DCS #4, she was observed doing R #7's [redacted]

B. On 11/08/18 at 8:34 am, during an interview with DCS #4, she confirmed that she did the [redacted] and that she is not a nurse. DCS #4 stated that because R #s 2 & 7 have shaky hands, she does their [redacted]

C. On 11/14/19 at 11:34 am, during an observation of a med-pass by DCS #4 for R #2, the resident had a difficulty doing [redacted] After several cueing attempts, DCS #4 did the [redacted]

D. On 11/14/19 at 11:37 am, during an interview with DCS #4, she confirmed the observation that

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A 035	Continued From page 45 R #2 was not able to do [redacted] Finding related to MARs: E. Record review of R #6's MAR dated [redacted]/18 to [redacted]/18 revealed no documentation of [redacted] F. Record review of R #6's Narcotic Record revealed that: [redacted] G. On 11/13/18 at 4:30 pm, during an interview with the Administrator, she confirmed that the order for R #6's [redacted] was never transferred to the MAR. She also confirmed that R #6 was given [redacted] on the day of [redacted] death.	A 035		
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only.	A 037		

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A 037	Continued From page 46 (3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet. B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010]	A 037		

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A 037	Continued From page 47 This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (2) (10) Based on observation and interview, the facility failed to ensure: 1. Cleaning supplies/chemicals were stored securely and not accessible to residents, some with Dementia (memory loss) or mental illness. 2. Clean laundry was stored in an area free of germs and bacteria. This deficient practice has the potential for all 44 (R #s 1-44) residents identified on the census list, provided by the Resident Care Coordinator on 11/06/18 to be at risk of injury or illness requiring emergency medical treatment if: 1. They consume or spill the cleaning supplies on their face or body. 2. The clean laundry becomes contaminated with germs and/or bacteria. The findings are: A. On 11/15/18 at 7:15 am, during an observation of a cleaning cart and table in the laundry room (unlocked and accessible to residents) the following was observed: 1. Mop and mop bucket. 2. 2-32oz (ounce) bottle of bleach cleaner. 3. 1-32oz bottle of sanitizing cleaner. 4. 1-32oz bottle of urine cleaner. 5. 1-32oz bottle of window cleaner. 6. 1-32oz can of scrubbing cleaner. 7. 1-32oz can of polish/cleaner. 8. 1-32oz can of silver polish/cleaner. 9. 1-32oz can of oven cleaner. 10. 1-32oz bottle of biodegradable emulsifier. 11. 1-64oz box of baking soda.	A 037		

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A 037	Continued From page 48 12. 1-21oz can of comet. 13. 1-2lb (pound) plastic container of drain cleaner. 14. 1-35lb plastic container of powdered laundry soap (not closed). B. On 11/15/18 at 7:22 am, during an observation of the laundry room closet the following was observed: 1. A mop bucket with dirty water and a vacuum cleaner were observed being stored in the laundry room closet with clean laundry and fire system equipment. 2. A rack with a garbage bag (uncovered) was observed to have garbage in it being stored with the clean laundry. The Administrator stated it was supposed to be used for dirty laundry which sits directly under the clean linen storage. C. On 11/15/18 at 7:35 am, during an interview with the Administrator, she confirmed the above listed laundry room and closet observations. D. On 11/19/18 at 11:02 am, during an observation, the laundry room was observed to be unlocked and accessible to residents. E. On 11/19/18 at 11:05 am, during an interview with the Administrator, she confirmed that the laundry room was unlocked and accessible to residents.	A 037		
A 048	7 NMAC 8.2.48 Electrical System ELECTRICAL SYSTEM: A. All fuse and breaker boxes shall be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility shall know the	A 048		

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A 048	Continued From page 49 location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances shall be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear. (2) Extension cords shall not be used. The use of a multi-socket united laboratories approved (U/L APPROVED) surge protector with integrated circuit breaker no greater than six (6) feet in length is permitted for the intended purpose and not as an extension cord. [7.8.2.48 NMAC - Rp, 7.8.2.49 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.48 210.8 Ground Fault Circuit Interrupter Protection for Personnel 210.8 (B) Other than dwelling units. All 125 volt, single phase, 15 and 20 ampere receptacles installed in the locations specified in 210.8 (B)(1) through (8) shall have ground fault circuit interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception 1: to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow melting, de-icing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22 as applicable.	A 048		

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A 048	Continued From page 50 Exception 2: to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B) (2)shall be permitted for only those receptacles outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 6 ft. of the outside edge of the sink. Exception 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. 314.25: Covers and Canopies. In completed installations, each box shall have a cover, faceplate, lampholder, or luminaire canopy, except where the installation complies with 410.24(B)	A 048		

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A 048	Continued From page 51 406.5(F): Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. Electrical outlets within 3 feet of a water supply shall be equipped with Ground Fault Circuit Interrupters (GFCI). NFPA 99, 2012 10.2.4 Adapters and Extension Cords. 10.2.4.1 Three-prong to two-prong adapters shall not be permitted. 10.2.4.2 Adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. 10.2.4.2.1 All adapters shall be listed for the purpose. 10.2.4.2.2 Attachment plugs and fittings shall be listed for the purpose. 10.2.4.2.3 The cabling shall comply with 10.2.3. Based on observation and interview, the facility failed to ensure that all electrical outlets within three (3) feet of a water supply were Ground Fault Circuit Interrupter (GFCI) protectors. This deficient practice has the potential for all 44 (R #s 1-44) residents identified on the census provided by the Resident Care Coordinator on 11/06/18, to be at risk of harm or death from an electric shock if water was to come in contact with electricity. The findings are: A. On 11/15/18 at 1:30 pm, during an observation of the laundry room the electrical outlet that the washer was plugged into was observed to not be a GFCI outlet.	A 048		

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A 048	Continued From page 52 B. On 11/15/18 at 2:30 pm, during an interview with the Administrator, she confirmed that the electrical outlet that the washer was plugged into was observed to not be a GFCI outlet.	A 048		
A 049	7 NMAC 8.2.49 Doors DOORS: A. No door in any means of egress shall be locked against egress when the building is occupied. (1) Exit doors may be provided with a night latch, dead bolt, or security chain, provided these devices are operable from the inside, by any occupant, without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed forty-eight (48) inches above the finished floor. (2) If locks are not readily operable by all occupants within the building, the locks must: 1) unlock upon activation of the fire detection or sprinkler system and 2) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written approval from the building, fire and licensing authorities having jurisdiction. B. All exit doors shall have a minimum width of thirty-six (36) inches. (1) Facilities with a capacity of ten (10) or more residents shall have exit doors leading to the outside of the facility that open outward. (2) Facilities with a capacity of fifty (50) or more residents must provide panic hardware at the exit doors. (3) No door or path of travel to a means of egress shall be less than twenty-eight (28) inches wide. C. All resident sleeping room doors must be at least one and three-quarters (1 3/4) inch solid	A 049		

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A 049	Continued From page 53 core construction. D. Bathroom doors may be twenty-four (24) inches wide. Facilities with four (4) or more residents shall have at least one bathroom for every eight (8) residents with a door clearance of thirty-six (36) inches for access by persons with disabilities. E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside. F. All doors shall readily open from the inside. G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms. [7.8.2.49 NMAC - Rp, 7.8.2.50 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.49 F Based on observation and interview, the facility failed to ensure that the public restroom doors could be readily opened from the inside. This deficient practice has the potential for all 44 (R #s 1-44) residents listed on the census, provided by the Resident Care Coordinator on 11/06/18, to be at risk of harm, injury, or death if a fire or other emergency requiring evacuation were to occur and they became trapped and unable to get out of the bathroom to exit the building. The findings are: A. On 11/19/18 at 11:03 am, during an observation of the public restroom next to laundry room, the door was observed to not readily open because the lock on the door did not release when the the handle/knob was turned. B. On 11/19/18 at 11:05 am, during an interview with the Administrator, she confirmed that the	A 049		

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A 049	Continued From page 54 lock on the door of the public restroom next to the laundry room did not readily open. C. On 11/19/18 at 11:22 am, during an observation of the public restroom by the kitchen, the lock on the door was observed to not to not readily open because the lock on the door did not release when the the handle/knob was turned. D. On 11/19/18 at 11:29 am, during an interview with the Administrator, she confirmed that the lock on the door of the public restroom next to the kitchen did not readily open.	A 049		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010]	A 063		

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A 063	Continued From page 55 This REQUIREMENT is not met as evidenced by: 7.8.2.63 B Reference NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition: 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. Based on observation and interview the facility failed to complete monthly inspections of the fire extinguishers throughout the building. This deficient practice has the potential of harm to all 44 (R #s 1-44) residents identified on the census provided by the Resident Care Coordinator (RCC) on 11/06/18 and all occupants of the building if a fire extinguisher doesn't operate correctly in the event of a fire. The findings are: A. Record review of the monthly inspection signature tags attached to the fire extinguishers revealed that they need to be inspected monthly by the facility B. On 11/14/18 at 10:35 am, during observation and tour of the facility, the monthly inspection signature cards attached to the fire extinguishers, were blank for August 2018, September 2018, and October 2018. C. On 11/14/18 at 10:35 am, during an interview,	A 063		

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A 063	Continued From page 56 the Administrator confirmed the monthly inspection signature cards attached to the fire extinguishers, were blank for August 2018, September 2018, and October 2018.	A 063		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 A B Based on record review and interview, the facility failed to conduct fire drills correctly. This deficient practice has the potential for all 44 (R #s 1-44) residents identified on the census provided by the	A 065		

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A 065	Continued From page 57 Resident Care Coordinator (RCC) on 11/06/18 and all occupants of the building, to be at risk of harm and/or death if the staff are not prepared to carry out a safe evacuation of residents and notification of the fire department in the event of a fire. The findings are: A. Record review of the facility's fire drill records for the past year revealed: 1. There was no record of a fire drill for February, 2018; 2. There was no evacuation time in total minutes for 01/06/18, 04/23/18, and 10/24/18. 3. There was no fire drill conducted during the eight hours of night each quarter (every 3 months) from 11:00 pm to 7:00 am from November 2017 to April 2018. 4. There was no documentation of the fire alarm system being used to conduct the drills. B. On 11/15/18 at 9:35 am, during interview with the Administrator, she confirmed the above findings for the fire drills.	A 065		
A 066	7 NMAC 8.2.66 Staff and Resident Fire and Safety Training STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff of the facility shall know the location and the proper use of fire extinguishers and the other procedures to be followed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff shall be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails,	A 066		

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A 066	Continued From page 58 frayed electrical cords, blocked exits or exit-ways and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident admitted to the facility shall be given an orientation tour of the facility to include the location of the exits, fire extinguishers and telephones and shall be instructed in the actions to be taken in case of fire or other emergencies. D. Fire drill procedures. The facility must conduct at least one (1) fire drill each month. (1) Fire drills shall be held at different times of the day, evening and night. (2) The fire alarm system or detector system in the facility shall be used in the fire drills. During the night, the fire drill alarm may be silenced. (3) During the fire drills, emphasis shall be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall show the date and time of the drill, the number of personnel participating in the drill, any problem(s) noted during the drill and the evacuation time in total minutes. (5) The local fire department may be requested to supervise and participate in the fire drills. [7.8.2.66 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.66 A-D (1, 2 & 4) Bases on record review and interview, the facility failed to ensure that: 1. The Direct Care Staff (DCS) had received	A 066		

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A 066	Continued From page 59 fire safety and evacuation training at orientation and annually. 2. Residents/Family members received fire safety and evacuation orientation upon admission to the facility. 3. Conduct and document monthly fire drills These deficient practices have the potential for all 44 (R #s 1-44) residents listed on the census, provided by the Resident Care Coordinator (RCC) on 11/06/18 and all occupants, to be at risk of harm, injury, or death if a fire or other emergency were to occur because: 1. The DCS do not know how to safely evacuate the residents and other occupants of the facility. 2. Residents/family members do not know where the fire safety equipment is, the evacuation route, and/or where the exits are. 3. Fire drills are not conducted and documented as required to ensure staff and residents/family know when, and where to evacuate. The findings are: Findings related to staff fire safety and evacuation training: A. Record review of the Resident Care Coordinator (RCC) and Direct Care Staff (DCS #s 1-3) training files revealed no documentation that they had received Fire Safety and Evacuation training at orientation and/or annually. B. On 11/15/18 at 9:00 am, during an interview with the Administrator, she confirmed that there was no documentation that the RCC and DCS #s 1-3 received Fire Safety and Evacuation training at orientation and/or annually.	A 066		

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A 066	Continued From page 60 Findings related to resident Fire Safety and Evacuation orientation: C. Record review of R #s 1, 3 & 4 resident charts revealed no documentation that they received Fire Safety and Evacuation orientation upon admission to the facility. D. On 11/08/18 at 2:38 pm, during an interview with the Administrator, she confirmed that there was not documentation that R #s 1, 3 & 4 received fire safety and evacuation orientation upon admission. Findings related to fire drills: E. Record review of the facility's fire drill records for 2018 revealed there was no: 1. Record of a fire drill for February, 2018. 2. Evacuation times in total minutes for 01/06/18, 04/23/18, or 10/24/18. 3. Fire drill conducted during the eight hours of night shift each quarter (every 3 months) from 11:00 pm to 7:00 am from November, 2017 through April, 2018; and 4. Documentation of the fire alarm system being used to conduct the drills. F. On 11/15/18 at 9:35 am, during an interview with the Administrator, she confirmed the above listed fire drill findings.	A 066		
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living	A 068		

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A 068	Continued From page 61 facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or	A 068		

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A 068	Continued From page 62	A 068		

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

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A 068	Continued From page 63 (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated	A 068		

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A 068	Continued From page 64 section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal	A 068		

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depending on the nature of the issue.
(ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified.
E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements:
(1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP;
(2) private visiting space:
(a) physical space for private family visits;
(b) accommodations for family members to remain with the patient throughout the night; and
(c) accommodations for family privacy after a resident ' s death.
F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid.
[7.8.2.68 NMAC - N, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.68 C (2) D (2)

Based on record review and interview, the facility failed to ensure for 2 (R #s 1 & 2) of 2 (R #s 1 & 2) residents identified as receiving hospice services that:

1. A team meeting was convened prior to admitting/retaining residents who have chosen to receive hospice services.

2. The Individual Service Plans (ISPs) included, documentation of coordination of care

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WESTWIND HOUSE	6600 LOS VOLCANES NW ALBUQUERQUE, NM 87121

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A 068	Continued From page 66 with the hospice provider. This deficient practice has the potential for residents receiving hospice services, to be at risk of harm and not receiving the higher level of care/services needed if: 1. A resident is admitted/retained at an increased level of care needed, beyond what the facility is able to provide. 2. If the Direct Care Staff (DCS) are not aware of what care/services the hospice agency will provide and what care/services they are to provide. The findings are: A. Record review of R #1's resident file revealed: 1. No documentation that a team meeting was convened prior to [redacted] admission to hospice services on [redacted]/18. 2. ISPs (dated 12/18/17 & 07/13/18) had not been updated to include coordination of care with hospice agency when admitted to hospice services on [redacted]/18. B. Record review of R #2's ISPs (dated 07/11/17, 07/11/18 & 08/10/18) revealed that the ISP had not been updated to include coordination of care with hospice agency when admitted to hospice services on [redacted]/18. C. On 11/13/18 at 2:30 pm, during an interview with the Administrator, she confirmed that: 1. There was no team meeting convened for R #1 prior to being admitted to hospice on [redacted]/18. 2. The ISPs for R #s 1 & 2 were not updated to include coordination of care with the hospice agency.	A 068		

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A 070	Continued From page 67	A 070		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 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	A 070		

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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 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

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A 070	Continued From page 69 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 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	A 070		

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A 070	Continued From page 70 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 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	A 070		

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A 070	Continued From page 71	A 070		

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 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

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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 3 (RCC and DCS #s 2 &3) of 4 (RCC and DCS #s 1-3) Resident Care Coordinator and Direct Care Staff:

1. Were cleared by the Employee Abuse Registry prior to hire.

2. Applications and fingerprints for the Caregiver Criminal History Screening program (CCHSP) were submitted within twenty (20) days from date of hire.

These deficient practices have the potential to affect the safety and welfare of all residents, 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 Resident Care Coordinator's (RCC) employee file hire date 03/05/17 revealed that the EAR application was not submitted/clearance received until 04/12/17, and the CCHP application and fingerprints were not submitted until 04/20/17,

B. Record review of DCS #2's employee file hire date 10/10/16 revealed that the EAR application was not submitted/clearance received until 10/18/16,

C. Record review of DCS #3's employee file hire date 05/30/18 revealed that the EAR applications

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A 070	Continued From page 73 (2) were not submitted/clearance received until 06/21/18 & 07/20/18. D. On 11/18/18 at 9:00 am, during an interview with the Administrator, she confirmed the EAR and CCHSP findings for the RCC and DCS #s 2 & 3.	A 070		