STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3004	A. BUILDING: _____ B. WING _____	08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF FOUR HILLS 2	13450 WENONAH SE ALBUQUERQUE, NM 87123

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A 000	Initial Comments An initial survey was completed on 08/19/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Deficiencies were cited as result of the survey.	A 000		
A 008	7 NMAC 8.2.8 General Licensing Requirements GENERAL LICENSING REQUIREMENTS: A. Licensure is required. No person or entity shall establish, maintain or operate an assisted living facility without first obtaining a license. B. Application for licensure. An initial or renewal application shall be made on the forms prescribed by and available from the licensing authority. The issuance of an application form is not a guarantee that the completed application will be accepted, or that the department will issue a license. Information provided by the facility and used by the licensing authority for the licensing process shall be accurate and truthful. The licensing authority will not issue a new license if the applicant has had a health facility license revoked or renewal denied or has surrendered a license under threat of revocation or denial of renewal. The licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of applicable rules found to be class A or class B deficiencies as defined in Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC or has been non-compliant with plans of correction. The licensing authority will not issue a license until the applicant has supplied all of the information that is required by this rule. Any facility that fails to participate in good faith by falsifying information presented in the licensing process shall be denied licensure by the department. The following information shall be submitted to the licensing authority for approval:	A 008	# i.e A008-The manager applied for another temporary license. The facility is operating the facility with a current license. The manager will ensure that the operators license will be current at all times.	8-20-2016

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A 008	Continued From page 1 (1) a letter of intent that includes the proposed physical address, the primary population of the facility and a summary of the proposed services; after the letter of intent has been received, an application packet including; the application form, fee schedule and the licensing rule will be issued to the applicant by the licensing authority; (2) the completed and notarized application and the appropriate non-refundable fee(s); (3) a program narrative identifying and detailing the geographic service area, the primary population including any special needs requirements, along with a full description of the services that the applicant proposes to provide including: (a) a description of the characteristics of the proposed population of the facility; (b) a description of the services and care that will be provided to the residents; (c) a description of the anticipated professional services to be offered to the residents; and (d) a description of the facility ' s relationship to other services and related programs in the service area and how the applicant will collaborate with them to achieve a system of care for the residents. (4) policies and procedures annotated to this rule; (5) evidence to establish that the applicant has sufficient financial assets to permit operation of the facility for a period of six (6) months; the evidence shall include a credit report from one of the three recognized credit bureaus with a minimum credit score of six-hundred fifty (650) or above; (6) copies of organizational documents to include the following list of items: (a) the names of all persons or business entities that have at least five percent (5%) ownership interest in the facility, whether direct or indirect	A 008		

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A 008	Continued From page 2	A 008		

and whether in profits, land or building; this includes the owners of any business entity which owns all or part of the land or building;
(b) the identities of all creditors that hold a security interest in the premises, whether land or building;
(c) any changes in ownership or management shall be reported to the department within thirty (30) days;
(7) building plans as required at 7.8.2.41 NMAC of this rule;
(8) fire authority approval as required at 7.8.2.60 NMAC of this rule;
(9) a letter of approval or exemption from the local health authority having jurisdiction for the food service and the kitchen facility;
(10) a copy of liquid waste disposal and treatment system permit from local health authority having jurisdiction;
(11) approval from local zoning authority;
(12) building approval (certificate of occupancy); and
(13) any other information that the applicant wishes to provide or that the licensing authority may request.
C. Application for amended license. A licensee shall submit an application for an amended license and the required non-refundable fee to the licensing authority prior to a change with the facility. An amended license is required for a change of: location, administrator, facility name, capacity or any modification or addition to the building.
(1) An application for a change of the facility administrator or change of the administrator ' s name shall be submitted to the licensing authority within ten (10) business days of the change.
(2) An application for increase in capacity shall be accompanied by a building plan pursuant to

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A 008	Continued From page 3 7.8.2.41 NMAC of this rule. A facility shall not increase census until the licensing authority has reviewed and approved the increase and has issued a new license that reflects the approved increase in capacity. D. Application for license renewal. Each facility shall apply for a renewal of the annual license within thirty (30) business days prior to the license expiration date by submitting the following items: (1) an application and the required fee; (2) an updated program narrative, if the facility has changed the program or the focus of services; (3) the annual fire inspection report; and (4) the licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of this rule or has been noncompliant with plans of correction or payment of civil monetary penalties. E. License. Any person or entity that establishes, maintains or operates an assisted living facility shall obtain a license as required in this rule before accepting residents for care or providing services. (1) Each facility that provides care or treatment shall obtain a separate license. The license is non-transferable and is only valid for the facility to which it is originally issued and for the owner or operator to whom it is issued. It shall not be sold, reassigned or transferred. (2) The maximum capacity specified on the license shall not be exceeded. (3) If the facility is closed and the residents are removed from the facility, the license shall be returned to the licensing authority. Written notification shall be issued to all residents or the residents ' surrogate decision maker and the licensing authority at least thirty (30) calendar days prior to the closure.	A 008		

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A 008	Continued From page 4 F. Temporary license. (1) A temporary license may be issued to a new facility before residents are admitted provided that the facility has met all of the life safety code requirements as stated in this rule and policies and procedures for the facility have been reviewed and approved. (2) Upon receipt of a temporary license, the facility may begin to admit up to three (3) residents. (3) After the facility has admitted up to three (3) residents, the facility operator or owner shall request an initial health survey from the licensing authority. (4) Following a determination of compliance with this rule by the licensing authority, an annual license will be issued. The renewal date of the annual license is based on the initial date of the first temporary license. (5) The licensing authority has the right to determine compliance or noncompliance. (6) A temporary license shall cover a period of time, not to exceed one hundred twenty (120) calendar days. (7) No more than two (2) consecutive temporary licenses shall be issued. If a second temporary license is issued, an additional non-refundable fee is required. If all requirements are not met within the two hundred forty (240) day time frame, the applicant shall repeat the application process. G. Annual license. An annual license is issued for one (1) year for a facility that has met all the requirements of this rule. H. Display of license. The facility shall display the license in a conspicuous public place that is visible to residents, staff and visitors. I. Unlicensed facilities. Any person or entity that opens or maintains an assisted living facility without a license is subject to the imposition of	A 008		

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A 008	Continued From page 5 civil monetary penalties by the licensing authority. Failure to comply with the licensure requirements of this rule within ten (10) days of notice by the licensing authority may result in the following penalties pursuant to Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC. (1) A civil monetary penalty not to exceed five-thousand dollars ($5,000) per day. (2) A base civil monetary penalty, plus a per-day civil monetary penalty, plus the doubling of penalties as applicable, that continues until the facility is in compliance with the licensing requirements in this rule. (3) A cease and desist order to discontinue operation of a facility that is operating without a license. (4) Additional criminal penalties may apply and shall be imposed as necessary. [7.8.2.8 NMAC - Rp, 7.8.2.8 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.8 F. (7) Based on interview and observation, the facility failed to reapply for a temporary license prior to the expiration of the most recent license. This deficient practice led to the facility operating an assisted living without a current license. The findings are: A. On 08/16/16 at 4:05 pm, during a tour of the facility, it was observed that the most recent temporary license had expired on 07/07/16. B. On 08/16/16 at 4:05 pm, during an interview with the Manager, she acknowledged the temporary license had expired.	A 008		

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A 016	Continued From page 6	A 016		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC. 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	A 016	# i.e A016- From 8-19-2016 every new hire will have a Ear completed prior to hire date.The manager of this facility will conduct Ear screenings before every new hire.	8-19-2016

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

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A 016	Continued From page 8 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to 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	A 016		

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A 016	Continued From page 9	A 016		

provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.
E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.
F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.
[7.1.12.8 NMAC - N, 01/01/2006]

Based on record review and interview, the facility failed to ensure that 4 (DCS #s 3, 4, 6, and 8) of 10 (DCS #s 1-10) Direct Care Staff met the

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A 016	Continued From page 10 requirements for the Employee Abuse Registry (EAR) inquiry prior to date of hire for DCS records reviewed. This deficient practice has the potential to affect all residents by allowing a person who has been placed on the EAR for Abuse, Neglect, and/or Exploitation of an adult to have access to all residents. The findings are: A. Record review findings related to Employee Abuse Registry (EAR) inquiry: 1. DCS #3's staff records revealed a date of hire as 04/09/16 but the inquiry to the EAR was not completed until 04/20/16, eleven (11) days after hire. 2. DCS #4's staff records revealed a date of hire as 05/04/15 but the inquiry to the EAR was not completed until 05/08/15 four (4) days after hire. 3. DCS #6's staff records revealed a date of hire as 03/30/16 but the inquiry to the EAR was not completed until 04/08/16 nine (9) days after hire. 4. DCS #8's staff records revealed a date of hire as 06/06/16 but the inquiry to the EAR was not completed until 06/09/16 three (3) days after hire. B. On 08/19/16 at 9:40 am, during an interview the Manager acknowledged that the inquiries to the EAR were not completed for DCS #s 3, 4, 6, and 8 until after their dates of hire.	A 016		
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and	A 022		

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A 022	Continued From page 11 procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained; (7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction; (8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks; (9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSES) rating, if applicable; (10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of	A 022	# i.e. A022- The manager requested a copy of custodial drug permit .We were able to obtain a copy of the custodial drug permit. The manager has posted the custodial drug permit in the office in the facility and will ensure it is current and posted at all times.	8-19-2016

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A 022	Continued From page 12 transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of emergencies: (a) an emergency that affects just the facility; and (b) a region/area wide emergency; (11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC); (12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and (13) vaccination records for pets in the facility. B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority: (1) a copy of the facility license; (2) employee personnel records, including an application for employment, training records and personnel actions: (a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC; (b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and (3) a copy of all waivers or variances granted by the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone;	A 022		

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BEEHIVE HOMES OF FOUR HILLS 2	13450 WENONAH SE ALBUQUERQUE, NM 87123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 022	Continued From page 13 (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas; (7) accommodation of resident ' s pets; and (8) resident use of electric blankets and appliances. D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas: (1) actions to be taken in case of accidents or emergencies; (2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission; (3) policy for medication errors; (4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.); (5) the handling of resident's funds, if the facility provides such services; (6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy;	A 022		

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A 022	Continued From page 14 (12) admission agreement; (13) admission records; (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.22 A. 12 Based on observation and interview, the facility failed to have a record of a Custodial Drug Permit to legally store medications for the residents. This deficient practice could lead to the misuse,	A 022		

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A 022	Continued From page 15 improper storage, and improper handling of the facility's medication regimen for all 10 (R #1-10) residents if the facility is not monitored by the Board of Pharmacy. A. On 08/18/16 at 5:35 pm, during tour of the facility, there was no Custodial Drug Permit from the State Board of Pharmacy observed posted any where in the facility. B. On 08/19/16 at 9:40 am, during the exit interview, the Administrator acknowledged that no Custodial Drug Permit had been located.	A 022		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a 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	A 025		

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A 025	Continued From page 16 communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 025	# i.e. A025-New resident evaluations were conducted for every resident of the facility to assess their current level of care and to ensure the facility can and will provide care according to their needs. The manager will follow requirements of the state regulations to ensure that initial evaluations are completed within 15 days prior to admission. Dates and signatures will be maintained on these documents.	8-19-2016

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A 025	Continued From page 17 Refer to 7.8.2.25 B & C. (16) Based on record review and interview the facility failed to ensure that resident evaluations were signed, dated and completed as required for two (R #s 1 & 2) of three (R #s 1, 2 & 3) residents whose evaluations were reviewed for accuracy. These deficient practices have the potential for the residents to not receive the appropriate care and assistance they need as changes in their health status occur due to the evaluations not being completed and reviewed as required. The findings are: A. Record review of R #1's facility file revealed an evaluation dated 6/23 with no year and no signature of the person evaluating the resident. B. Record review of R #2's facility file revealed an evaluation with no date, no signature of the person evaluating the resident, and the evaluation was not complete. C. On 08/15/16 at 2:00 pm, during an interview, the Manager confirmed the evaluations for R #1 and 2 were not dated or signed and the evaluation for R #2 was incomplete.	A 025		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment	A 034		

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A 034	Continued From page 18 and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document:	A 034	# i.e A034- A - Oxygen tanks were removed from the room #1and moved to the garage,n placed on racks and away from water heater and Hvac systems.1 oxygen tank was left in rm #1 and placed on holding rack. #i.e A034- B -same as A #i.e A034- C- All oxygen tanks were moved and now stored away from fuel fired hot water heaters and Hvac untis. All oxygen tanks were placed on racks. #i.e A034-D -Same as C The manager will ensure these procedures are followed for storage of oxygen tanks. # i.e A034_ E- The manager will ensure that the medication cart will remain locked when unattended so that medications are not accessible to residents and other occupants of the building. The manager separated all non oral and oral medications into different compartments. The manager will ensure this regulation is followed. # i.e A034- F - Same as E	8-19-2016 8-19-2016 8-19-2016 8-19-2016 8-19-2016 8-19-2016

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A 034	Continued From page 19 (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and,	A 034		

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A 034	Continued From page 20 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: Refer to 7.8.2.34 A. (1 & 2) Refer to 7.8.2.34 A. (7) NFPA 99/1999 4-3.5.2.2 Storage of Cylinders and Containers Level I a) Facility authorities, in consultation with medical staff and other trained personnel, shall provide and enforce regulations for the storage and handling of cylinders and containers of oxygen in storage rooms of approved construction, and for the safe handling of these agents in locations. In storage locations, cylinders shall be properly secured in racks or adequately fastened in the upright position. b) Non Flammable Gases 1. Storage shall be planned so that cylinders can be used in the order in which they are received. 2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. 3. Cylinders stored in the open shall be protected	A 034		

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A 034	Continued From page 21	A 034		

against extremes of weather and from the ground beneath to prevent rusting.
During winter, cylinders stored in the open shall be protected against accumulations of ice or snow. In summer, cylinders stored in the open shall be screened against continuous exposure to direct rays of the sun in those locations where extreme temperatures prevail.

Based on observation, interview, and record review, the facility failed to protect the health and safety of all of the facility's 10 (R # 1-10) residents by:
1. not locking the storage of residents' medications;
2. not storing oxygen cylinders properly in a rack or fastened in the upright position and failed to store them in a ventilated storage area.
These deficient practices could lead to medications being stolen, tampered with, being administered to a resident or someone it is not prescribed for, could lead to discrepancies in the medication regimen, and in the event of a fire or a oxygen cylinder being knocked over, oxygen cylinders may act like a missile with the potential to harm all residents and all occupants of the building. The findings are:

A. On 08/16/16 at 4:20 pm, during a tour of the facility, five (5) 22 cubic feet oxygen bottles stored in resident room # 1 and 4 were not secured in a rack and were free-standing.

B. On 08/16/16 at 4:20 pm, during an interview, the Manager confirmed there were five (5) unsecured 22 cubic feet oxygen bottles stored in resident room # 1 and 4.

C. On 08/18/16 at 4:30 pm, during a tour of the facility, five (5) 22 cubic feet oxygen bottles were

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A 034	Continued From page 22 stored in the garage and exposed to the fuel fired hot water heaters. D. On 08/18/16 at 4:30 pm, during an interview, the Administrator confirmed there were five (5) 22 cubic feet oxygen bottles stored in the garage and exposed to the fuel fired hot water heaters. E. On 08/18/16 at 5:25 pm, during a tour of the facility, the medication cart with the residents' medications was observed to be unlocked, unattended, and accessible to all residents and occupants of the building. It was also observed that non-oral medications were stored together with oral medications and not in separate compartments. F. On 08/18/16 at 5:30 pm, during an interview, the Manager confirmed the medication cart with the residents' medications was unlocked, unattended, and accessible to all residents and occupants of the building. She further confirmed the non-oral medications were stored together with the oral medications and not in separate compartments.	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	A 035		

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A 035	Continued From page 23 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 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	A 035	# i.e A035- Every resident medication has been audited to include diagnosis or reason documentation of time given, why it was given The desired results obtained from our problems encountered with scheduled or controlled substances that are taken as needed (prn). Documentation that specifies whether a medication was missed or given. Manager will ensure that medications are entered correctly and documented accurately.	8-19-2016

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A 035	Continued From page 24 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 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	A 035		

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A 035	Continued From page 25 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. 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	A 035		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 035	Continued From page 26 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: Refer to 7.8.2.35 G. (4), (17), (19), & (20) Based on record review and interview, the facility failed to ensure that the Medication Administration Record (MAR) for 3 of 3 (R #s 1-3) residents whose MARs were reviewed included the following: 1. the diagnosis or reason for any of the medications on the MAR; 2. documentation of the time given, why it was given, the desired results obtained from or problems encountered with Schedule II - IV controlled substances that are taken As Needed (PRN) ; 3. documentation of whether a medication was missed, refused, or given; 4. documentation that specified whether a medication was not yet prescribed, discontinued, or not scheduled (the electronic MAR uses the same symbol for all 3); and 5. documentation of vital signs on the dates vital signs were scheduled. These deficient practices could lead to caregivers not understanding the desired results of a medication, not knowing what the medication is for, administering a Schedule II - IV controlled substance PRN medication too soon after an	A 035		

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	3004	A. BUILDING: _____ B. WING _____	08/19/2016

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earlier dose, and caused failure to document on the MARs if the medications were given or not given. The findings are:

A. Record review of the July 2016 and August 2016 electronic MARs for R # 1 revealed the following:

1. There was no diagnosis or reason for the medications on the MARs for any of the 20 prescribed medications.
2. For the medication, "Levetiracetam (anticonvulsant) 500 mg (milligram); Take one (1) tablet by mouth at bedtime." There were no notes or initialed entries to signify whether or not the medication was given or not given on 07/02/16, 07/03/16, 07/10/16, 08/02/16, 08/05/16, and 08/09/16.
3. For the medication, "Prazosin (blood pressure medication) 1 mg; Take one (1) capsule by mouth at bedtime." There were no notes or initialed entries to signify whether or not the medication was given or not given on 07/02/16, 07/03/16, 07/10/16, 08/02/16, 08/05/16, and 08/09/16.
4. For the medication, "Simethicone (excess gas medication) 80 mg; Take one (1) tablet by mouth four times daily." There were no notes or initialed entries to signify whether or not the medication was given or not given on the following dates;
a. 08/02/16 for the second daily dose;
b. 08/02/16 for the third daily dose; and
c. 07/01/16 through 07/06/16, 07/09/16 through 07/11/16, 07/15/16, 07/19/16, 07/28/15, 08/02/16, 08/04/16 through 08/06/16, and 08/12/16 for the fourth daily doses.
5. For the medication, "Metformin (Treatment of Type II Diabetes) 1000 mg; Take one (1) tablet by mouth twice daily." There were no notes or initialed entries to signify whether or not the medication was given or not given on 08/02/16 for

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the second daily dose and 08/03/16 for the first daily dose.

B. Record review of the August 2016 electronic MAR for R #2 revealed the following:

1. For the medication Acetaminophen-Hydrocodone (moderate to severe pain reliever) 325-7.5; "Take one (1) (7.5-325 mg) tablet by mouth every four hours as needed for pain." It was entered on the MAR seven (7) times as follows:
a. The first and second entries dated 08/05/16 were listed as Acetaminophen 1;
b. The third entry dated 08/05/16 was listed as, "Acetaminophen 325-7.5;"
c. The fourth entry dated 08/05/16 was listed as "Acetaminophen 325;"
d. The fifth entry dated 08/09/16 was listed as "Acetaminophen 325;"
e. The sixth entry dated 08/05/16 was listed as "Acetaminophen (C2) 325-7.5;"
f. The seventh entry dated 08/09/16 was listed as "Acetaminophen (C2) 325-7.5;"
g. The first 5 entries were all errors as the medication was listed incorrectly and they indicated, "Take 2 tablets every 4 hours as needed for mild pain" when the order was for 1 tablet every four hours as needed for pain. However, these entries were not coded or documented as errors; and
h. The first 5 entries all have the symbol (code) that has 3 possible meanings, Not Yet Prescribed/Discontinued/Not Scheduled in the spaces for staff initials. The facility should have 3 different codes specific to each different entry type and these entries should have been coded as errors.

2. For the medication furosemide (diuretic)

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20 mg; Take 1 (20 mg) tablet by mouth once daily. It was entered four times on the MAR as follows;
a. Three times had a start date of 08/05/16 that read; Take 1 tablet by mouth every morning.
b. The first and second entries were coded with the same symbol (code) with 3 different meanings.
c. The third entry with a start date of 08/05/16 read; Take 1 (20 mg) once daily. There was no change from the previous entries. From 08/10/16 through the end of the current month, the entries have the same symbol (code) with 3 different meanings.
d. The fourth entry with a start date of 08/09/16 read; Take 1 (20 mg) once daily, a new order, but the spaces for staff initials before the new order have the same symbol (code) with 3 different meanings. All 3 are incorrect as it should have been coded as a new order.
3. For the medication Gabapentin (nerve pain) 300 mg; "Take one (1 mg) capsule by mouth three (3) times daily," was entered 5 times as follows;
a. The first and second entries dated 08/05/16 have PRN (as needed) dated 08/05/16 and all spaces for the whole month have the symbol __ with 3 different meanings;
b. The first, second, and third entries are coded with the same symbol __ with 3 different meanings;
c. The third entry dated 08/05/16 is regularly scheduled and not PRN (as needed); and
d. The fourth entry dated 08/09/16 which means the 08/05/16 order was discontinued but the coding for the discontinued have the same symbol __ with 3 different meanings from 08/09/16 through the end of August, 2016.
4. Further, there was no diagnosis or reason on the MARs for the prescribed medications,

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Furosemide (Lasix) 20 MG or Gabapentin 300 mg;
5. For the medication, "Ondanestron (Zofran) 4 mg; Take one (4 mg) tablet by mouth every four hours as needed for nausea, (PRN). It was initialed as given once on 08/10/16, twice on 08/11/16, three times on 08/15/16, and once on 08/16/16. There was no record of the time of day it was given, the reasons it was given, or the outcomes from the doses of the medication to R #2.

C. Record review of the July 2016 and August, 2016 MARs for R #3 revealed the following:
1. For the medication Acetaminophen (pain reliever) 650 mg; Take 1 tablet by mouth every 6 hours as needed for pain or fever, do not exceed 3000 mg in 24 hours. It was given 6 times as follows:
a. Once on 07/22/16, once on 07/29/16, twice on 08/10/16, once on 08/13/16, and once on 08/16/16.
b. There was no documentation showing the time of day of when it was given for any of the 6 doses.
c. There was no documentation of why it was given for any of the 6 doses.
d. There was no documentation of the outcome from the six doses of the medication.
2. For the medications Atropine (decrease production of saliva) 1%; Give 2 drops by mouth under the tongue every four hours as needed for excess secretions, Lorazepam (antianxiety) 0.5 mg; Take 1 tablet by mouth every four hours as needed for anxiety/agitation, Morphine sulfate (moderate to severe pain reliever) 0.25 ml (mili-liters), Give 0.25 ml by mouth every hour as needed for pain or shortness of breath, and Senna (laxative) 8.6 mg; Take 1 tablet by mouth every day as needed for constipation with the

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A 035	Continued From page 31 following; a. They were all given once on 07/22/16; b. There was no documentation showing the time of day of when they were given; c. There was no documentation of why they were given; and d. There was no documentation of the outcome from the doses of the medications given to R# 3. 3. There was no reason for medications or diagnosis documented on the MARs for the following medications: a. Aspirin (pain/fever reducer) 325 mg, Take 1 tablet by mouth once daily; b. Duo Heb [sic] 0.5 mg/3 mg, Take 1 vial by mouth every four hours [Should have been DuoNeb (Dual Nebulizer) 1 inhalation in each nostril every four hours, 0.5-2.5 mg/3 ml for COPD]; c. Furosemide (diuretic) 40 mg, Take 1 tablet by mouth once daily; d. Levothyroxine (thyroid medication) 75 mcg (microgram), Take 1 tablet by mouth once daily; e. Probiotic (digestive system), Take 1 tablespoon by once daily; and f. Symbicort (asthma medication) 80-4.5 mcg, Take 2 puffs by mouth twice daily. 4. There were orders on the July 2016 and August 2016 MARs which read, "Vital sign N/A Take blood pressure, temperature, and heart rate once weekly." a. The vitals were scheduled to be taken on 07/4/16, 07/11/16, 07/18/16, 07/25/16, 08/08/16, 08/15/16, 08/22/16, and 08/29/16. b. The spaces for entering the information were blank for 07/18/16, 07/25/16, 08/22/16, and 08/29/16. D. On 08/18/16 at 10:50 am, during an interview	A 035		

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A 035	Continued From page 32 with the Manager, the Manager confirmed that there was missing documentation in the MARs because 1) the electronic MAR did not have unique symbols for prescribed, discontinued, or not scheduled medications; 2) notes for PRN medications and 3) there were errors in the available documentation.	A 035		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it;	A 036	# i.e. A036- The facility manager will ensure that direct care staff wear a hair net or cap when preparing and serving food to the residents of the facility. All direct care staff will not have facial hair untrimmed or exposed.	8-19-2016

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A 036	Continued From page 33 posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of	A 036		

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A 036	Continued From page 34 action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be	A 036		

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A 036	Continued From page 35 maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated	A 036		

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A 036	Continued From page 36 and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used.	A 036		

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A 036	Continued From page 37 (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.36 C. (5) Based on observation and interview, the facility failed to ensure that Direct Care Staff (DCS) wear a hair net or cap when preparing and serving food to the facility's 10 (R #s 1-10) residents identified on the resident census list provided by the Administrator on 08/15/16. This deficient practice could lead to bacterial contamination of the food served to the residents. The findings are: A. On 08/17/16 at 7:20 am, during a tour of the facility, DCS #3 was observed cooking, preparing, and providing food to the residents without a hair net, instead was wearing a cap with several uncovered locks of hair hanging out of the cap and exposed facial hair. B. On 08/17/16 at 8:26 am, during a tour of the	A 036		

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A 036	Continued From page 38 facility, DCS #s 5 and 10 were observed preparing and serving food without hair nets or caps. Hair was exposed. C. On 08/18/16 at 8:30 am, in an interview with DCS #10, she confirmed she was preparing food for the residents without a hair net or cap.	A 036		
A 043	7 NMAC 8.2.43 Hazardous Areas HAZARDOUS AREAS: Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than one hundred (100) sq. ft., storage rooms more than fifty (50) sq. ft. but less than one hundred (100) sq. ft. not storing combustibles, storage rooms with more than one hundred (100) sq. ft. storing combustibles, chemical storage rooms with more than fifty (50) sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either: (1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter (3/4) hour rating; or (2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or (3) other hazardous areas shall be enclosed with walls with at least a twenty (20) minute fire rating and doors equivalent to one and three-quarter (1 3/4) inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. Boiler, furnace or fuel fired water heater rooms. For facilities with four (4) or more	A 043	# i.e A043- The facility maintenance will remove the combustible materials including lumber wooden doors and other construction materials away from the hot water heater.The manager will ensure that these materials will not be stored in a hazardous area.	8-19-2016

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A 043	Continued From page 39 residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one (1) hour. Doors to these rooms shall be one and three-quarter (1-3/4) inch solid core. [7.8.2.43 NMAC - Rp, 7.8.2.44 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that flammable liquids and combustible materials were not stored in a hazardous area next to the hot water heater. This deficient practice has the potential for all 10 (R #1-10) residents listed on the census, provided by the Administrator on 08/15/16 to be at risk of harm or death if a fire were to occur. The findings are: A. On 08/18/16 at 4:29 pm, during observation, combustible materials including lumber, wooden doors, and other construction materials were observed being stored in a hazardous area next to the fuel fired (natural gas) hot water heater. B. On 08/18/16 at 4:29 pm, during interview with the Administrator, she confirmed that combustible materials were stored in a hazardous area next to the fuel fired (natural gas) hot water heater.	A 043		
A 062	7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Facilities with nine (9) or more residents shall have an automatic fire protection	A 062		

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A 062	Continued From page 40 (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. [7.8.2.62 NMAC - Rp, 7.8.2.61 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.62 which refers to NFPA 13 NFPA 13.6.2.7.1 Plates, escutcheons, or other devices used to cover annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. Based on observation and interview, the facility failed to maintain the sprinkler heads throughout the facility. This deficient practice presents a risk that the sprinkler system may not function properly in the event of a fire emergency, which could result in harm or death to all 10 (R #1-10) residents identified by the Resident Census List provided by the Administrator on 08/15/16 and all occupants of the building in the event of a fire. The findings are: A. On 08/18/16 at 4:04 pm, during the tour of the facility with the Administrator, observation of numerous sprinkler heads throughout the building were observed to have dropped down away from the ceiling leaving the hole or annular opening exposed and not sealed by the escutcheon plate (shield that surrounds). This left an opening around each affected sprinkler head into the attic space allowing a path for smoke and fire to pass through. B. On 08/18/15 at 4:04 pm, during an interview	A 062	# i.e A062- The manager contacted our contractor to fix the sprinkler heads. The sprinkler heads will be fixed no later than 1-13-2017. We will continue to have fire safety inspections to ensure the sprinkler heads to not drop.	1-13-2017

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A 062	Continued From page 41 with the Administrator while touring the facility, she confirmed that there were problems with the sprinkler head installations which left exposed openings around the sprinkler heads.	A 062		
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following 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	A 068	# I. e A068- The Manager will ensure all hospice and home health agencies will leave documentation of their visits with the residents on hospice or home health services.The facility manager will check files to ensure proper documentation is done. Corrective action was taken on 8-19-2016	8-19-2016

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A 068	Continued From page 42 for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (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	A 068		

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A 068	Continued From page 43 includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (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	A 068		

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A 068	Continued From page 44 resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall 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.	A 068		

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A 068	Continued From page 45 (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified. 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:	A 068		

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A 068	Continued From page 46 Refer to 7.8.2.68 D (3) (b) Based on record review and interview, the facility failed to ensure that the hospice provider left documentation of the care and services (visit notes) provided by hospice for 1 (R #3) of 1 (R #3) resident receiving hospice services. If the facility does not have the visit notes at the facility, then the resident may not receive the appropriate level of care due to staff not knowing what services the hospice agency has provided. The findings are: A. Record review of R #3's resident file revealed no documentation (visit notes) of the the care and services provided by the hospice agency. B. On 08/18/16 at 8:30 am, during interview with the Administrator, she confirmed that there were no visit notes from R #3's hospice provider regarding the care and services he should have received.	A 068		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC.	A 070	# i.e A070- The manager will ensure that all employees will have the Ear screening prior to hire. The manager will ensure that all Ear screening will be conducted before hiring.	8-19-2016

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A 070	Continued From page 47 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: Refer to 7.8.2.70 E. Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.	A 070		

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A 070	Continued From page 48 B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with	A 070		

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A 070	Continued From page 49 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] Based on record review and interview, the facility failed to ensure that 4 (DCS #s 3, 4, 6, and 8) of 10 (DCS #s 1-10) Direct Care Staff met the requirements for the Employee Abuse Registry (EAR) inquiry prior to date of hire for DCS records reviewed. This deficient practice has the potential to affect residents by allowing a person who has been placed on the EAR for Abuse, Neglect, and/or Exploitation of an adult to have access to all residents. The findings are: 1. DCS #3's staff records revealed a date of hire as 04/09/16 but the inquiry to the EAR was not completed until 04/20/16, eleven (11) days after hire. 2. DCS #4's staff records revealed a date of hire as 05/04/15 but the inquiry to the EAR was not completed until 05/08/15 four (4) days after hire. 3. DCS #6's staff records revealed a date of hire as 03/30/16 but the inquiry to the EAR was not completed until 04/08/16 nine (9) days after hire. 4. DCS #8's staff records revealed a date of hire as 06/06/16 but the inquiry to the EAR was not completed until 06/09/16 three (3) days after hire. B. On 08/19/16 at 9:40 am, during an interview	A 070		

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A 070	Continued From page 50 the Manager acknowledged that the inquiries to the EAR were not completed for DCS #s 3, 4, 6, and 8 until after their dates of hire.	A 070		