STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2285	A. BUILDING: _____ B. WING _____	C 10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	601 W CHERRY LANE CARLSBAD, NM 88220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 10/26/17 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint Intake NM#30385 was substantiated with deficiencies cited.	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC.	A 016		

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

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A 016	Continued From page 2 This REQUIREMENT is not met as evidenced by: 7.8.2.16 B (3) Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to	A 016		

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A 016	Continued From page 3	A 016		

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

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

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

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A 016	Continued From page 6 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 for 1 (DCS #6) of 2 (DCS #s 4 and 6) Direct Care Staff reviewed for pre-employment requirements had the Employee Abuse Registry (EAR) submitted prior-to-hire. This deficient practice could affect the safety and welfare of all residents by being provided care by staff who may have a previous history of abusing, neglecting, or exploiting residents and/or is a convicted felon. The findings are: A. Record review of the DCS #6's file (hire date: 10/05/17) revealed that the EAR was submitted on 10/10/17, not prior to hire. B. On 10/26/17 at 10:45 am, during an interview with the Administrator, she confirmed that the	A 016		

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A 016	Continued From page 7 EAR was submitted on 10/10/17, for DCS #6 and not submitted prior to hire.	A 016		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice	A 020		

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A 020	Continued From page 8 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: (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);	A 020		

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A 020	Continued From page 9 (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 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	A 020		

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A 020	Continued From page 10 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 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 C (1) (2) (a) D (1)	A 020		

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A 020	Continued From page 11 Based on Record review and interview the facility failed to ensure for 4 (R #s 1-4) of 4 (R #s 1-4) residents that are receiving hospice services that: 1. A team meeting was convened prior to admitting/retaining residents who have elected to receive hospice services. 2. Coordination of care was documented with the hospice provider on the Individual Service Plan (ISP). This deficient practice has the potential for residents receiving hospice services to be at risk of harm if: 1. A higher level of care and services is needed than the facility would normally provide. 2. The Direct Care Staff (DCS) do not know what services they are to provide and what services the hospice agency will provide. The findings are: A. Record review of R #1's file revealed: 1. The last ISP was conducted on 04/10/17 and an ISP was not reviewed or revised to include coordination of care between hospice agency and facility when hospice services began on [redacted]/17. 2. No documentation that a team meeting took place before the resident was admitted to hospice on [redacted]/17. B. Record review of R #2's file revealed: 1. ISP dated 08/23/17 did not have coordination of care between the hospice agency and the facility added when hospice services began on [redacted]/17. 2. No documentation that a team meeting took place before the resident was admitted to hospice on [redacted]/17.	A 020		

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A 020	Continued From page 12 C. Record review of R #3's file revealed: 1. The last ISP was conducted on 06/19/17 and an ISP was not reviewed or revised and to include coordination of care between hospice agency and the facility when hospice services began on [redacted]/17. 2. No documentation that a team meeting took place before the resident was admitted to hospice on [redacted]/17. D. Record review of R #4's file revealed: 1. The last ISP was conducted on 08/31/17 and an ISP was not reviewed or revised and to include coordination of care between hospice agency and the facility when hospice services began on [redacted]/17. 2. No documentation that a team meeting took place before the resident was admitted to hospice on [redacted]17. E. On 10/26/17 at 8:00 am, during interview with the Assistant Manager, she confirmed that R #s 1-4 did not have revised ISPs when changes in conditions occurred to include coordination of care between the hospice agency and the facility and no documentation that a team meeting was convened prior to admitting/retaining residents who receive hospice services.	A 020		
A 024	7 NMAC 8.2.24 Assistance with Daily Living ASSISTANCE WITH DAILY LIVING: The facility shall supervise and assist the residents, as necessary, with health, hygiene and grooming needs, to include but not limited to the following: A. eating; B. dressing; C. oral hygiene; D. bathing;	A 024		

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A 024	Continued From page 13 E. grooming; F. mobility; and G. toileting. [7.8.2.24 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.24 A Based on record review and interview the facility neglected to ensure for 1 (R #1) of 1 (R #1) resident identified as having a high risk of choking and possible aspiration (food/liquid/objects going down into lungs), that he was supervised at all times while eating to ensure he did not swallow food or other items could cause him to choke. This deficient practice resulted in actual harm to the resident who swallowed an orange slice gummy candy and part of a napkin, causing him to choke, require emergency medical services, and admission to the hospital where he later died (Cardiac Arrest-heart stopped working). If high risk residents are not supervised at all times when food is available then they are at risk of harm, injury, or death from choking or aspiration. The findings are: A. Record review of the facility Self-Report to the Licensing Authority dated 10/22/17 revealed that R #1 was sitting in the dining area, the Direct Care Staff (DCS #3) saw [redacted] and thought [redacted] was choking, then DCS #2 removed an orange gummy candy and a napkin from [redacted] mouth. DCS #3 called the hospice agency, then saw that resident was turning blue and [redacted] body went limp, then she called 911. Emergency Medical Services (EMS) responded within 10 minutes and took resident to the hospital.	A 024		

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A 024	Continued From page 14 B. Record review of R#1's hospital Medical Records dated 10/21/17 revealed that [redacted] arrived at the emergency room (ER) via ambulance at 5:13 pm, with a complaint "choked/choking due to a possible [redacted] At 5:23 pm, an x-ray technician found R #1 semi-kneeling and slumped over [redacted] bed, [redacted] was placed on the bed, and was found to be [redacted] per family R #1's Do Not Resuscitate choice was confirmed and wishes for no further treatment was honored. Resident was pronounced dead at 6:47 pm." C. Record review of R #1's Progress Notes dated 08/03/17 thru 08/11/17 revealed the following: 1. On 08/03/17 R #1 was "eating in the dining room started coughing and choking on food, vigorous coughing saying 'it is stuck'." Family was notified and EMS were called. Resident was transported to the hospital. [redacted] was still coughing when leaving the facility. 2. On [redacted]/17 R #1 complained of choking, family notified, EMS were called, resident was transported to the hospital and was admitted. D. Record review of the hospital Discharge Orders dated 08/03/17, revealed that R #1 was seen in the Emergency Department for choking. E. Record review of the hospital Discharge Orders dated 08/11/17, revealed that R #1 was admitted to the hospital due to [redacted] R #1 was discharged back to the facility with orders for a puree (food has been ground, pressed and/or strained to a consistency of a soft, smooth, thick paste (similar to a thick pudding)) diet and thickened liquids (nectar).	A 024		

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A 024	Continued From page 15 F. On 10/26/17 at 8:13 am, during an interview with the Administrator, she stated that she was told by the DCS [name unknown] that a friend of R #3's brought in gummy candies and was sharing them with other residents. DCS #s 2 and 3 were not aware that R #1 had swallowed a piece of the candy and a napkin until after [redacted] was found choking. The Administrator also stated that to her knowledge there were no DCS in the dining room to supervise while R #1 was sitting at the table eating his snack before [redacted] was observed to have a napkin in [redacted] mouth and started choking. G. On 10/26/17 at 2:39 pm, during an interview with DCS #3, she stated that on 10/21/17 when she came on shift (3:00 to 11:00 pm) R #1 was sitting in the dining room at a table with 2 other residents. She observed that R #1 had been given some chocolate mouse for snack because [redacted] was on a pureed diet (due to past choking incidents) and, then around 3:10 pm to 3:15 pm, she went to do a medication count and get report from DCS #s 1 and 4. While in the medication room with DCS #s 1 and 4, a friend of R #3's stopped and offered the them some orange slice gummy candies, then R #3's friend turned left towards the exit door and/or the dining room. Later as she was getting the dining area set up for dinner she noticed that R #1 had a napkin stuck in the right side of [redacted] mouth. She stated that she does not give R #1 napkins because [redacted] will dunk it in [redacted] pureed food and eat it. She informed DCS #2 who asked R #1 if [redacted] had anything in [redacted] mouth, R #1 started choking, DCS #2 told her to call R #1's hospice provider, however, because it was taking to long for Hospice staff to come to the phone she hung up and called 911. As she hung up she saw that R #1 had lost color in [redacted] face and [redacted] lips were	A 024		

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A 024	Continued From page 16	A 024		

turning blue. EMS arrived within 8 minutes and were able to get R #1 breathing again. DCS #3 stated that when R #1 started choking [redacted] spit out an orange gummy candy, but continued to try and cough up something, the orange gummy slice that [redacted] did cough up was still whole and R #1 had not bitten into it. DCS #3 stated that she did see R #5 who was sitting at the opposite end of the table eating a gummy orange slice before she went to her room.

H. On 10/26/17 at 3:02 pm, during interview with DCS #4, she stated that R #1 was in a good mood and was sitting at the table eating a snack, she thinks it was chocolate pudding. At change of shift, she [DCS #4], DCS #3, and maybe DCS #1 were in the medication room, when a friend of R #3's came by and offered them some orange slice gummy candy. DCS #4 does not remember which way the friend went after she left the medication room.

I. On 10/26/17 at 3:20 pm, during observation with the Administrator and Assistant Manager of the facility's surveillance video of the incident dated 10/21/17, the following was observed:

1. At 3:06 pm, the friend of R #3 was observed offering and leaving something (suspected to be orange slice gummy candy) on the table where R #s 1, 2, and 5 were sitting. There were no DCS observed in the dining room during that time.

2. At 4:27 pm, DCS #2 was observed leaving the table and the dining room for the last time (DCS #2 had entered, sat with residents at the table and left the table/area several times since 3:06 pm).

3. At 4:32 pm, DCS #3 was observed cleaning and setting the tables for dinner.

4. At 4:35 pm, R #1 was observed to be

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A 024	Continued From page 17 choking/coughing. The observation was confirmed by the Administrator and Assistant Manager. J. On 10/26/17 at 3:40 pm, during interview with DCS #2, he stated that DCS #3 informed him that R #1 had something in [redacted] mouth, he went to R #1 who spit out an orange candy and a piece of napkin (inch or less long) was hanging from the corner of [redacted] mouth. DCS #2 removed the napkin, resident started to choke, instructed DCS #3 to call hospice nurse. While DCS #3 was calling hospice, he started doing back blows, R #1's arms started to shake, [redacted] eyes rolled back, color turned blue, and [redacted] lost consciousness, and was out for 10-15 seconds. DCS #2 told DCS #3 to call 911. R #1 woke up, [redacted] color went back to normal, but [redacted] continued to spit up mucus, and was still trying to cough something up. EMS arrived within 10 minutes and took R #1 to the hospital. DCS #2 stated that when he last left the table/dining room, the orange slices that had been brought by another resident's friend were in the center of the table near the salt shakers closer to R #2, where he thought R #1 could not get them. He also stated that the reason he kept going back and forth to the table when not assisting other residents was because both R #s 1 and 2 were fall risks, had puree diets, and R #1 had choked in the past.	A 024		
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	A 025		

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A 025	Continued From page 18 the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender	A 025		

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A 025	Continued From page 19 within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 B Based on record review and interview the facility failed to ensure for 2 (R #s 1 and 3) of 4 (R #s 1-4) residents whose evaluations/assessments were reviewed for compliance were updated when there was a change in condition. This deficient practice has the potential for residents to not receive the increased level of care and services needed if the evaluations/assessments have not been updated to reflect their increased level of care. The findings are: A. Record review of R #1's evaluation/assessment dated 04/10/17, revealed it was not updated when he had the following changes in condition: 1. [redacted] was admitted to hospice services on [redacted]17. 2. [redacted] was diagnosed as a [redacted]	A 025		

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A 025	Continued From page 20 [redacted]/17. B. Record review of R #3's evaluation/assessment dated [redacted]17 revealed it was not updated when [redacted] had a decline in [redacted] overall health condition and was admitted to hospice services on [redacted]17. C. On 10/25/17 at 3:30 pm, during an interview with the Administrator and Assistant Manager, they confirmed that the evaluations/assessments for R #s 1 and 3 were not updated when they had changes in their health conditions.	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 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;	A 026		

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A 026	Continued From page 21 (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 1-4) of 4 (R #s 1-4) residents who are receiving hospice services that the Individual Service Plan (ISP) was accurate and correct included the following: 1. Revisions and updates when a change in condition occurred. 2. Documentation of coordination of care with the hospice provider. This deficient practice has the potential for residents to be at risk of harm if they do not receive the appropriate care and assistance they need as changes in their health status occurs. The findings are:	A 026		

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A 026	Continued From page 22 A. Record review of R #1's file revealed that the last ISP was conducted on 04/10/17 and the ISP was not reviewed or revised to include coordination of care between the hospice agency and facility when hospice services began on 07/24/17. B. Record review of R #1's file revealed that on 08/11/17 [redacted] was discharged from the hospital with physician's orders for a puree (food has been ground, pressed and/or strained to a consistency of a soft, smooth, thick paste (similar to a thick pudding)) diet and thickened liquids (nectar) due to choking and possible aspiration (food/liquid/objects going down into lungs), the last ISP was conducted on 04/10/17 and was not revised to include [redacted] change of condition and the physician's new dietary orders. C. Record review of R #2's file revealed that the ISP dated 08/23/17 did not include coordination of care between the hospice agency and the facility when hospice services began on 08/21/17. D. Record review of R #3's file revealed that the last ISP was conducted on 06/19/17 and an ISP was not reviewed or revised to include coordination of care between the hospice agency and the facility when hospice services began on 09/22/17. E. Record review of R #4's file revealed that the last ISP was conducted on 08/31/17 and an ISP was not reviewed or revised to include coordination of care between the hospice agency and the facility when hospice services began on 10/04/17. F. On 10/26/17 at 8:00 am, during an interview with the Assistant Manager, she confirmed that R	A 026		

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A 026	Continued From page 23 #s 1-4 did not have revised ISPs when changes in conditions occurred and did not include coordination of care between the hospice agency and the facility.	A 026		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010]	A 032		

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A 032	Continued From page 24 This REQUIREMENT is not met as evidenced by: 7.8.32 A (1) (2) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct	A 032		

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knowledge of the incident assists with the preparation of the incident report form.

Based on record review and interview, the facility failed to ensure that all incidents of suspected or known resident abuse, neglect, or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and others were reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. This deficient practice has the potential for all 13 (R #s 1-13) residents listed on the census provided by the Assistant Manager on 10/25/17 to be at risk of being abused, neglected, and/or not receiving needed medical care and services if incidents are not being reported and there is no oversite by the Licensing Authority. The findings are:

A. Record review of R #1's Progress Notes dated 08/03/17 thru 08/11/17 revealed the following:

1. On 08/03/17 R #1 was [redacted] Family was notified and Emergency Medical Technicians (EMTs) were called. Resident was transported to the hospital. He was still coughing when leaving the facility.

2. On 08/10/17 R #1 complained of choking, family notified, EMTs were called, resident was transported to the hospital and was admitted.

B. Record review of the hospital Discharge Orders dated 08/03/17, revealed that R #1 was seen in the Emergency Department for [redacted]

C. Record review of R #1's Resident Chart, revealed no documentation that an internal incident report had been completed for the 08/03/17 and/or the 08/10/17 choking incidents

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A 032	Continued From page 26 requiring EMT and emergency medical services/admission to the hospital. There was no documentation that either incident was reported to the Licensing Authority. D. On 10/26/17 at 9:16 am, during an interview with the Assistant Manager, she confirmed that no internal incident reports were completed for R #1's [redacted]/17 and [redacted]/17 and that neither incident was reported to the Licensing Authority.	A 032		
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 (9) the ombudsman. C. The resident rights shall be posted in a	A 033		

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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;
(b) are free from financial abuse and misappropriation by facility staff or management;

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A 033	Continued From page 28 (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; (p) shall not be required to work for the facility; and	A 033		

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A 033	Continued From page 29 (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 (11) (a) Based on record review and interview the facility neglected to ensure for 1 (R #1) of 1 (R #1) resident identified as having a high risk of [redacted] that he was supervised at all times while eating to ensure he did not swallow food or other items that could cause him to choke. This deficient practice resulted in actual harm to the resident who swallowed an orange slice gummy candy and part of a napkin, causing him to choke, require emergency medical services, and admission to the hospital where he later died. If high risk residents are not supervised at all times, then they are at risk of harm, injury, or death from choking/aspiration. The findings are: A. Record review of the facility's Self-Report to the Licensing Authority dated 10/22/17 revealed that R #1 was sitting in the dining area, Direct Care Staff (DCS #3) saw [redacted] and thought [redacted] was [redacted] then DCS #2 removed an orange gummy candy and a napkin from [redacted] DCS #3 called the hospice agency, then saw that	A 033		

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resident was [redacted] then she called 911. Emergency Medical Services (EMS) responded within 10 minutes and took resident to the hospital.

B. Record review of R#1's hospital Medical Records dated 10/21/17 revealed that [redacted] arrived at the emergency room (ER) via ambulance at 5:13 pm, with a complaint [redacted] At 5:23 pm, an x-ray technician found R #1 [redacted] R #1's Do Not Resuscitate choice was confirmed and wishes for no further treatment was honored. Resident was [redacted]

C. Record review of R #1's Progress Notes dated 08/03/17 to 08/11/17 revealed the following:

1. On 08/03/17 R #1 was [redacted] Family was notified and EMS were called. Resident was transported to the hospital. [redacted] when leaving the facility.

2. On 08/10/17 R #1 complained of [redacted] family notified, EMS were called, resident was transported to the hospital and was admitted.

D. Record review of the hospital Discharge Orders dated [redacted]/17, revealed that R #1 was seen in the Emergency Department for [redacted]

E. Record review of the hospital Discharge Orders dated 08/11/17, revealed that R #1 was admitted to the hospital due to [redacted] R #1 was discharged back to the facility with orders for a puree (food has been ground, pressed and/or

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strained to a consistency of a soft, smooth, thick paste (similar to a thick pudding)) diet and thickened liquids (nectar), the last Individual Service Plan (ISP) was conducted on 04/10/17 and was not revised to include [redacted] change of condition and the physician's new dietary orders.

F. On 10/26/17 at 8:13 am, during an interview with the Administrator, she stated that she was told by the DCS [name unknown] that a friend of R #3's brought in gummy candies and was sharing them with other residents. DCS #s 2 and 3 were not aware that R #1 had swallowed a piece of the candy and a napkin until after [redacted] was found [redacted] The Administrator also stated that to her knowledge there were no DCS in the dining room to supervise while R #1 was sitting at the table eating [redacted] snack before [redacted] was observed to have a napkin in [redacted] mouth and started [redacted]

G. On 10/26/17 at 2:39 pm, during an interview with DCS #3, she stated "when she came on shift (3:00 to 11:00 pm) R #1 was sitting in the dining room at a table with 2 other residents. She observed that the previous shift had given [redacted] some chocolate mousse for snack due to [redacted] being on a pureed diet (due to past choking incidents) and, then around 3:10-3:15 pm, she went to do a medication count and get report with the off-going shift. While in the medication room with DCS #1 and 4, a friend of R #3 stopped and offered them some orange slice gummy candies, she then turned left towards the exit door and/or the dining room. Later as she was getting the dining area set up for dinner she noticed that R #1 had a napkin stuck in the right side of [redacted] mouth. She stated that she does not give [redacted] napkins because [redacted] will dunk it in [redacted] pureed food and eat it. She informed DCS #2 who asked R #1 if [redacted] had anything in [redacted] mouth, R #1 started

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choking, DCS #2 told her to call R #1's hospice provider, however, because it was taking to long for hospice staff to come to the phone she hung up and called 911. As she hung up she saw that R #1 had [redacted] EMS arrive within 8 minutes and were able to get R #1 breathing again. DCS #3 stated that when R #1 started choking [redacted] spit out an orange gummy candy, but continued to try and [redacted] the orange gummy slice that [redacted] did [redacted] was still whole and [redacted] had not bitten into it. DCS #3 stated that about 3:00 pm to 3:10 pm she did see R #5 who was sitting at the opposite end of the table eating a gummy orange slice before [redacted] went to [redacted] around 3:15 pm. When asked if [redacted] knew what aspiration was, DCS stated that [redacted] did not know what it meant, she just knew that R #1 was on a pureed diet and thickened liquids. DCS #1 says [redacted] told the Assistant Manager, that [redacted] should tell the DCS more about residents on a pureed diet".

H. On 10/26/17 at 3:02 pm, during an interview with DCS #4, she stated that "on 10/21/17, R #1 was in a good mood and was sitting at the table eating a snack, she thinks it was chocolate pudding. At change of shift, she [DCS #4], DCS #3, and maybe DCS #1 were in the medication room, when a friend of R #3's came by the medication room and offered them (DCS) some orange slice gummy candy. DCS #4 does not remember which way the friend went after [redacted] left the medication room."

I. On 10/26/17 at 3:20 pm, during an observation with the Administrator and Assistant Manager of the facility's surveillance video of the incident dated 10/21/17, the following was observed:

1. At 3:06 pm, the friend of R #3 was

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observed offering and leaving something (suspected to be orange slice gummy candy) on the table where R #s 1, 2, and 5 were sitting. There were no DCS observed in the dining room during that time.

2. At 4:27 pm, DCS #2 was observed leaving the table and the dining room for the last time (DCS #2 had entered, sat with residents at the table and left the table/area several times since 3:06 pm).

3. At 4:32 pm, DCS #3 was observed cleaning and setting the tables for dinner.

4. At 4:35 pm, R #1 was observed to be [redacted]

J. On 10/26/17 at 3:20 pm, during an interview with the Administrator and Assistant Manager, they confirmed what was observed on the surveillance video regarding R #1.

K. On 10/26/17 at 3:40 pm, during an interview with DCS #2, he stated "that DCS #3 informed him that R #1 had something in [redacted] mouth, he went to R #1 who spit out an orange candy and a piece of napkin (inch or less long) was hanging from the corner of [redacted] DCS #2 removed the napkin, resident started to [redacted] instructed DCS #3 to call hospice nurse. While DCS #3 was calling hospice, he started doing back blows, R #1's arms started to shake, [redacted] eyes rolled back, color turned blue, and [redacted] lost consciousness, and was out for 10-15 seconds. DCS #2 told DCS #3 to call 911. R #1 woke up, [redacted] color went back to normal, but [redacted] continued to spit up mucus, and was still trying to cough something up. EMS arrived within 10 minutes and took R #1 to the hospital. DCS #2 stated that when he last left the table/dining room, the orange slices that had been brought by another resident's friend were in the center of the table

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A 033	Continued From page 34 near the salt shakers closer to R #2, where he thought R #1 could not get them. He also stated that the reason he kept going back and forth to the table when not assisting other residents was because both R #s 1 and 2 were fall risks, had puree diets, and R #1 had choked in the past".	A 033		
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; posted menus shall be followed and any	A 036		

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A 036	Continued From page 35 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 action taken to comply with recommendations or	A 036		

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A 036	Continued From page 36 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 maintained in the facility and available for	A 036		

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A 036	Continued From page 37 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 and labeled. Unused leftover food shall be	A 036		

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A 036	Continued From page 38 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. (2) Condensed, evaporated, or dried milk	A 036		

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A 036	Continued From page 39 products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.36 A (1) (b) (e) B (2) (3) Based on record review and interview, the facility failed to ensure that: 1. The snacks are posted on the daily menu. 2. Residents were being served food as ordered by their physician 3. A dietary record of residents' physician ordered therapeutic diets was maintained. 4. The Food Establishment Permit was current and the most current kitchen licensing inspection report (annual inspection) was on file and available for review. This deficient practice has the potential for all 13 residents (R #s 1-13) identified on the resident census, provided by the Assistant Manager on 10/25/17, to be at risk of harm if: 1. Residents are unaware that snacks are	A 036		

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A 036	Continued From page 40	A 036		

available between meals.

2. Residents are eating the incorrect food/diet that does not meet their needs.

3. The cooks are not aware of the special dietary needs (food/food preparation) of the residents and they suffer illness or harm.

4. Contracting foodborne illnesses and needing additional medical services if the kitchen is not inspected annually to ensure it is operating in a safe and sanitary manner in compliance with the rules and regulations.

The findings are:

Findings for Pureed Food

A. Record review of R #2's file revealed that the Health Condition form with the last entry dated 08/23/17 stated R #2 is not on a therapeutic diet.

B. On 10/25/17 at 5:05 pm, during observation R #2, was observed eating food that had been pureed.

C. On 10/25/17 at 5:10 pm, during interview with Direct Care Staff (DCS) #5, she stated that she pureed the egg roll, the meat in soup, and crackers for R #2's evening meal at 5:00 pm.

D. On 10/25/17 at 5:15 pm, during interview with the Assistant Manager she confirmed that the Health Condition form dated 08/23/17 stated that R #2 was not on a therapeutic food diet.

Findings for Kitchen Inspection

E. Record review of the facility's Food Establishment Permit revealed it had expired on 08/31/17 and there was no annual inspection report available for review.

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A 036	Continued From page 41 F. On 10/26/16 at 12:20 pm, during interview with the Administrator and Assistant Manager, they confirmed that the facility's Food Establishment Permit had expired on 08/31/17 and there was no annual inspection report available for review. In addition, they could not confirm whether or not an annual inspection had occurred. Findings related to snacks/menus G. Record review of the weekly menus dated 09/03/17 to 10/28/17 revealed that there were no snacks listed on the menus. H. On 10/26/17 at 12:10 pm, during an interview with the Administrator and Assistant Manager, they confirmed that there were no snacks listed on the weekly menus dated 09/03/17 to 10/28/17. Findings related to therapeutic diet records I. Record request for dietary records for resident therapeutic diets, revealed there was no documentation of a dietary record of resident therapeutic diets maintained in the kitchen. J. On 10/26/17 at 10:15 am, during interview with the Cook, she stated she did not have a list of residents' therapeutic diets. She stated she thought the list/information would be kept in the medication room. During the interview another DCS [name unknown] told the Cook, "there should be card box in the kitchen drawers with all the therapeutic diets for residents in it." K. Record review of the diet cards revealed they were either outdated or for residents no longer at the facility. L. On 10/26/17 at 10:20 am, during interview with	A 036		

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A 036	Continued From page 42 the Administrator and Assistant Administrator, they confirmed that the dietary cards are no longer used, they do not have a record of therapeutic diets that is maintained in the kitchen available to the cooks, and any record of therapeutic/special diets for residents would be in their charts in the medication room.	A 036		
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.	A 068		

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A 068	Continued From page 43 (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (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.	A 068		

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A 068	Continued From page 44 (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (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	A 068		

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A 068	Continued From page 45 to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall 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.).	A 068		

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A 068	Continued From page 46 (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified. 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]	A 068		

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A 068	Continued From page 47 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 4 (R #s 1-4) of 4 (R #s 1-4) residents that are receiving hospice services that: 1. A team meeting was convened prior to admitting/retaining residents who have elected to receive hospice services. 2. Coordination of care was documented with the hospice provider on the Individual Service Plan (ISP). This deficient practice has the potential for residents receiving hospice services to be at risk of harm if: 1. Residents who require a higher level of care and services than the facility would normally provide is admitted/retained without a team meeting being convened to ensure the facility can meet their needs. 2. The Direct Care Staff (DCS) do not know what services they are to provide and what services the hospice agency will provide. The findings are: A. Record review of R #1's file revealed: 1. No documentation that a team meeting took place before the resident was admitted to hospice on [redacted]/17. 2. The last ISP was conducted on 04/10/17 and an ISP was not reviewed or revised to include coordination of care between the hospice agency and facility when hospice services began on [redacted]/17. 3. No documentation that the ISP conducted on 04/10/17 was revised/updated after R #1 was	A 068		

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discharged from the hospital on [redacted]/17 with physician's orders for a puree (food has been ground, pressed and/or strained to a consistency of a soft, smooth, thick paste (similar to a thick pudding)) diet and thickened liquids (nectar) due to choking and possible aspiration (food/liquid/objects going down into lungs), include his change of condition and the new physician's dietary orders.

B. Record review of R #2's file revealed:
1. No documentation that a team meeting took place before the resident was admitted to hospice on [redacted]/17.
2. [redacted] dated [redacted]/17 did not have coordination of care between the hospice agency and the facility added to the ISP when hospice services began on [redacted]/17.

C. Record review of R #3's file revealed:
1. No documentation that a team meeting took place before the resident was admitted to hospice on [redacted]/17.
2. The last [redacted] was conducted on [redacted]/17 and an ISP was not reviewed or revised and to include coordination of care between hospice agency and the facility when hospice services began on [redacted]/17.

D. Record review of R #4's file revealed:
1. No documentation that a team meeting took place before the resident was admitted to hospice on [redacted]/17.
2. The last [redacted] was conducted on [redacted]/17 and an [redacted] was not reviewed or revised and to include coordination of care between the hospice agency and the facility when hospice services began on [redacted]/17

E. On 10/26/17 at 8:00 am, during interview an

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A 068	Continued From page 49 with the Assistant Manager, she confirmed that R #s 1-4 did not have a revised [redacted] when changes in conditions occurred to include a coordination of care between the hospice agency and the facility and no documentation that a team meeting was convened prior to admitting/retaining residents receiving hospice services.	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. 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 E F Refer to 7.1.12 EMPLOYEE ABUSE	A 070		

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A 070	Continued From page 50 REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to 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	A 070		

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A 070	Continued From page 51 information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty 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	A 070		

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A 070	Continued From page 52 CAREGIVER EMPLOYMENT REQUIREMENTS: . . . D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these 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	A 070		

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A 070	Continued From page 53 impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with 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	A 070		

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A 070	Continued From page 54 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. 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation,	A 070		

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A 070	Continued From page 55 injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview the facility failed to ensure that: 1. Employee Abuse Registry (EAR) clearances were received prior-to-hire. 2. Incidents of suspected or known resident abuse, neglect, or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and others were reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday This deficient practice could affect the safety and welfare of all 13 (R #s 1-13) residents identified on the census provided by the Assistant Manager on 10/25/17 if: 1. Residents are being provided care by staff who may have a previous history of abusing, neglecting, or exploiting residents and/or is a convicted felon. 2. Residents are being abused, neglected, and/or not receiving needed medical care and services if incidents are not being reported and there is no oversite by the Licensing Authority. The findings are: Findings related to EARs A. Record review of the DCS #6's file (hire date:	A 070		

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A 070	Continued From page 56 10/05/17) revealed that the EAR was submitted on 10/10/17, not prior to hire. B. On 10/26/17 at 10:45 am, during an interview with the Administrator, she confirmed that the EAR was submitted on 10/10/17, for DCS #6 and not submitted prior to hire. Findings related to Incident Reporting C. Record review of R #1's Progress Notes dated 08/03/17 thru 08/11/17 revealed the following: 1. On 08/03/17 R #1 was "eating in the dining room started coughing and choking on food, vigorous coughing saying 'it is stuck'." Family was notified and (Emergency Medical Technicians (EMTs) were called. Resident was transported to the hospital. [redacted] was still coughing when leaving the facility. 2. On [redacted]/17 R #1 complained of choking, family notified, EMTs were called, resident was transported to the hospital and was admitted. D. Record review of the hospital Discharge Orders dated 08/03/17, revealed that R #1 was seen in the Emergency Department for choking. E. Record review of R #1's Resident Chart, revealed no documentation that an internal incident report had been completed for the 08/03/17 or 08/10/17 choking incidents requiring EMT and emergency medical services/admission to the hospital. There was no documentation that either incident was reported to the Licensing Authority. F. On 10/26/17 at 9:16 am, during an interview with the Assistant Manager, she confirmed that no internal incident reports were completed for R #1's choking incidents on 08/03/17 and 08/10/17 and that neither incident was reported to the	A 070		

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A 070	Continued From page 57 Licensing Authority.	A 070		