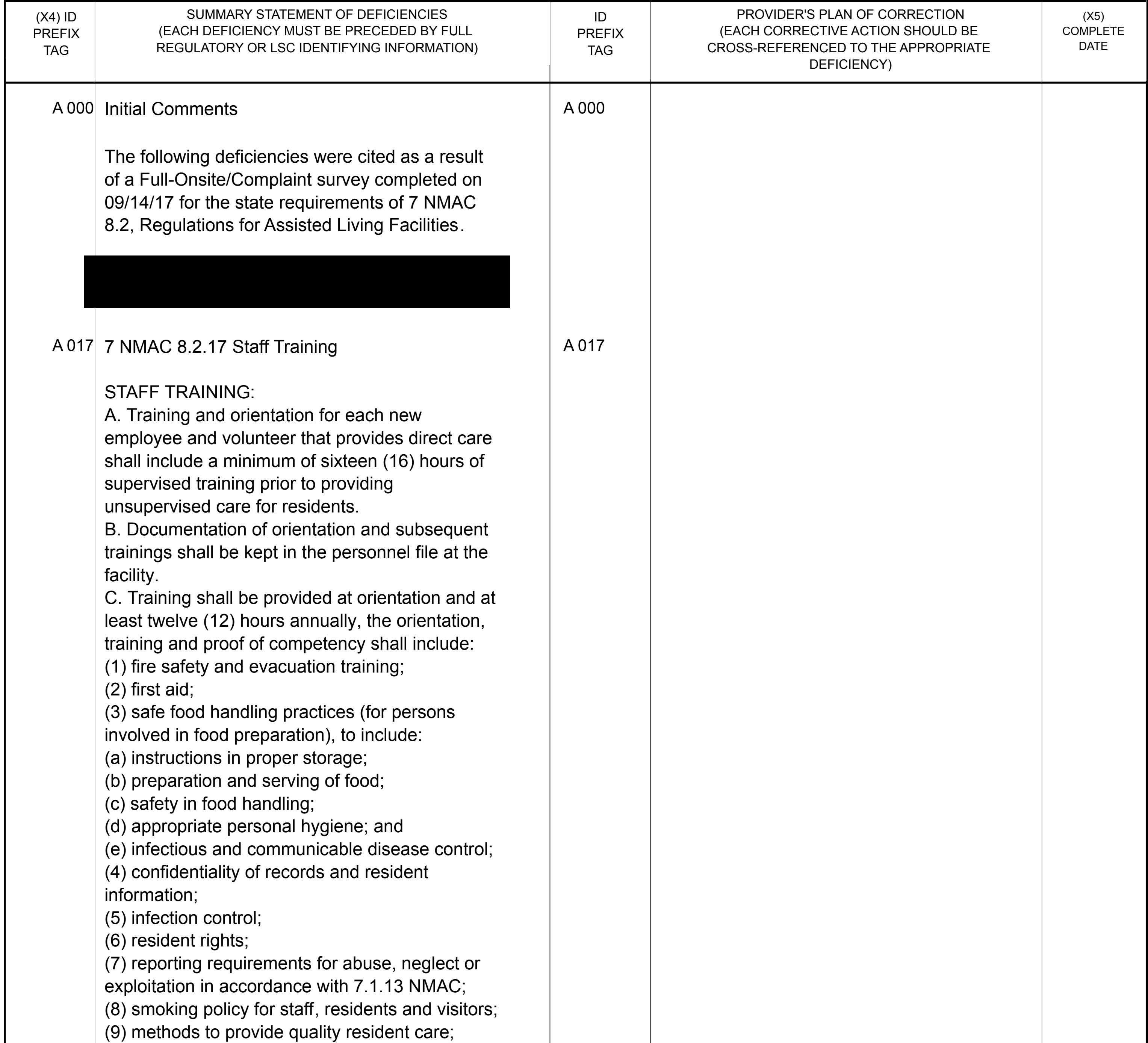
Division of Health Improvement



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5870	A. BUILDING: ______ B. WING ______	C 09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF FARMINGTON	**400 NORTH LOCKE ST FARMINGTON, NM 87401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited as a result of a Full-Onsite/Complaint survey completed on 09/14/17 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.	A 000		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care;	A 017		

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A 017	Continued From page 1	A 017		

(10) emergency procedures;
(11) medication assistance, including the certificate of training for staff that assist with medication delivery; and
(12) the proper way to implement a resident ISP for staff that assist with ISPs.
D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation.
[7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.17 C (1) (2) (3) (a) (b) (c) (d) (e) (5) (9) (12)

Based on record review and interview the facility failed to ensure for 1 (DCS #2) of 3 (DCS #s 1-3) Direct Care Staff employee training files reviewed for compliance received the 12-hours of orientation training. This deficient practice has the potential for all 12 residents identified on the census provided by the House Manager on 09/11/17, to be at risk of harm or injury if staff have not received training on the proper methods of providing care and services. The findings are:

A. Record review of DCS #2's training file revealed missing documentation for the required trainings:
1. Fire safety and evacuation training.
2. First aid.
3. Safe food handling practices to include:
   a. Instructions in proper storage.
   b. Preparation and serving of food.
   c. Safety in food handling.
   d. Appropriate personal hygiene.

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A 017	Continued From page 2 4. Infection control 5. Methods to provide quality resident care. 6. Individual Service Plan implementation. B. On 09/13/17 at 10:45 am, during an interview with the House Manager, she confirmed that DCS #2 has not completed the required training's listed above.	A 017		
A 019	7 NMAC 8.2.19 Staffing Ratios STAFFING RATIOS: The following staffing levels are the minimum requirements. A. The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents ' needs. (1) During resident waking hours, facilities shall have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents. (2) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty, awake and responsible for the care and supervision of the residents. (3) During resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises. (4) During resident sleeping hours, facilities with thirty-one (31) to sixty (60) residents shall have at least two (2) direct care staff persons on duty and awake at all times and at least one (1) additional staff person immediately available on the premises. (5) During resident sleeping hours, facilities with more than sixty-one (61) residents shall have at	A 019		

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A 019	Continued From page 3 least three (3) direct care staff persons on duty and awake at all times and one (1) additional staff person immediately available on the premises for each additional thirty (30) residents or fraction thereof in the facility. B. Upon request of the department, the facility shall provide the staffing ratios per each twenty-four (24) hour day for the past thirty (30) days. [7.8.2.19 NMAC - Rp, 7.8.2.18 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.19 A Based on record review and interview the facility failed to ensure that there was a sufficient number of Direct Care Staff (DCS) on duty to provide safe transfers for 3 (R #s 5-7) of 3 (R #s 5-7) residents identified by the House Manager and Administrator as requiring the assistance of a minimum of two DCS for all transfers. This deficient practice has the potential for residents who require the assistance of 2 DCS for all transfers be at risk of harm or injury if there if there is not a minimum of 2 DCS available to transfer residents safely. The findings are: A. Record review of R #5's Nursing Assessment dated 05/01/17, revealed that he requires total assist for transfers. B. Record review of R #6's Nursing Assessment dated 08/01/17, revealed that she requires total assist for transfers to/from wheelchair at all times. C. Record review of R #7's Nursing Assessment dated 08/01/17, revealed that she is bedridden, but does require the assistance of 2 DCS when	A 019		

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A 019	Continued From page 4	A 019		

transferred to the wheelchair.

D. On 09/14/17 at 9:00 am, during interview with the House Manager, she confirmed that the words "total assist" when written on a nursing assessment means that the resident required the assistance of 2 DCS for transfers.

E. Record review of staff schedule dated 09/01/17-09/14/17, revealed only one DCS was on duty/scheduled during resident sleeping hours.

F. On 09/14/17 at 6:45 pm, during interview with the Administrator and House Manager, they confirmed that R #s 5-7 required the assistance of a minimum of 2 DCS for all transfers and confirmed the facility only has 1 DCS scheduled/on duty during resident sleeping hours.

A 020 — 7 NMAC 8.2.20 Admissions and Discharge — A 020

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;

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A 020	Continued From page 5 (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (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	A 020		

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A 020	Continued From page 6	A 020		

written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and
(14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents.
B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following:
(1) ventilator dependency;
(2) pressure sores and decubitus ulcers (stage III or IV);
(3) intravenous therapy or injections;
(4) any condition requiring either physical or chemical restraints;
(5) nasogastric tubes;
(6) tracheostomy care;
(7) residents that present an imminent physical threat or danger to self or others;
(8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP;
(9) residents with a diagnosis that requires 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

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A 020	Continued From page 7	A 020		

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

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A 020	Continued From page 8	A 020		

resident.
D. Coordination of care.
(1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers.
(2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider.
[7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.20 A (12) (a) (14) C (1) D (1)

Based on record review and interview, the facility failed to ensure for 3 (R #s 2-4) of 3 (R #s 2-4) residents that:
1. The Admissions Agreement reviewed for compliance was accurate and included the following:
a. Admission agreement may be terminated "if" an appropriate placement is found for the resident.
b. A fifteen (15) days notice is given for termination for non-payment of rent.
c. facilities operating as a Memory Care Unit (MCU) must disclose evidence of staff specialty training to prospective residents.
2. A team meeting was convened prior to admitting/retaining residents who have elected to receive hospice services and there was documentation of coordination of care with the

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A 020	Continued From page 9 hospice provider on the Individual Service Plan (ISP). These deficient practices have the potential for residents to be at risk of harm if: 1. They are discharged before an appropriate placement was found. 2. They are terminated from the facility without a fifteen (15) day written notice for non-payment of rent. 3. Residents and/or Power of Attorney's not knowing if the facility provides the specialized care to meet the individual needs (physical, mental, social, etc) to maintain the highest level of quality of life. 4. If a higher level of care and services is needed than the facility would normally provide and/or if 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 #2's Admissions Agreement (not dated) revealed, missing required information for the following: 1. May be terminated if an appropriate placement is found for the resident. 2. A fifteen (15) days' notice is given for non-payment of rent. 3. Staff specialty training related to dementia and/or pertinent information. B. Record review of R #3's Admissions Agreement dated 05/02/17 revealed, missing required information for the following: 1. May be terminated if an appropriate placement is found for the resident. 2. A fifteen (15) days' notice is given for non-payment of rent. 3. Staff speciality training related to dementia	A 020		

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A 020	Continued From page 10 and/or pertinent information. C. Record review of R #4's Admissions Agreement dated 08/16/16 revealed, missing required information for the following: 1. May be terminated if an appropriate placement is found for the resident. 2. A fifteen (15) days' notice is given for non-payment of rent. 3. Staff specialty training related to dementia and/or pertinent information. D. On 09/13/17 at 10:30 am, during an interview with the Administrator, she confirmed for R #s 2-4 that the Admissions Agreements were missing the required above information. Findings related to hospice team meeting/coordination of care. E. Record review of R #2's ISP dated 08/11/17 revealed a hospice start date of 07/17/17. The ISP did not indicate coordination of care with the hospice provider and there was no documentation stating that a hospice team meeting was convened between the facility, resident/power of attorney and hospice agency. F. On 09/14/17 at 4:32 pm, during an interview with the House Manager, she confirmed that R #3's ISP dated 08/11/17 did not have coordination of care with the hospice provider and there was no documentation stating that a hospice team meeting was convened between the facility, resident/power of attorney and hospice agency.	A 020		
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies	A 022		

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A 022	Continued From page 11 FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained; (7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction; (8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks; (9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSES) rating, if applicable; (10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include	A 022		

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

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

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	5870	A. BUILDING: ______ B. WING ______	C 09/14/2017

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A 022	Continued From page 14 (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (12) admission agreement; (13) admission records; (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (8) C (8)	A 022		

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A 022	Continued From page 15 Based on record review and interview the facility failed to ensure that the facility: 1. Maintained records of the past 30-days of menus as served that included snacks. 2. House rules included the use of electric blankets and appliances. These deficient practices have the potential for all 12 (R #s 1-12) residents listed on the census, provided by the House Manager on 09/11/17 to be at risk of: 1. Not receiving healthy/nutritional meals and snacks, if there are not menus available for review by family, medical professionals, and Licensing Authority. 2. Being harmed, injured, and death if a fire were to be started by faulty electric blankets and/or appliances. The findings are: Findings related to menus: A. Record request for documentation of the past 30 days of menus as served, including snacks, revealed there were no menus available for review by the Licensing Authority. B. On 09/13/17 at 8:58 am, during interview with the House Manager, she confirmed that there was no documentation for review of the past 30-days of menus as served, including available snacks. Finding related to house rules: C. Record review of the facility House Rules, revealed that there was no rule pertaining to the use of electric blankets and/or appliances. D. On 09/14/17 at 9:03 am, during interview with the House Manager, she confirmed that the	A 022		

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A 022	Continued From page 16 House Rules did not include the use of electric blankets and/or appliances.	A 022		
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; (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;	A 026		

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A 026	Continued From page 17 (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) (2) (3) Based on record review and interview the facility failed to ensure that 2 (R #s 1 and 2) of 4 (R #1-4) residents whose Individual Service Plans (ISPs) were reviewed for compliance included the following: 1. Revisions and updates when a change in condition occurred. 2. Documentation of coordination of care with the hospice provider. 3. Signatures and dates as reviewed by license practical nurse (LPN), registered nurse (RN), or physicians extender (PE). These deficient practices have the potential for residents to be injured and/or not receiving the care and services if Direct Care Staff (DCS) don't know what care to provide and what care will be provided by the hospice provider and reviewed by the nurse for accuracy. The findings are: A. Record review of R #1's ISPs revealed that the: 1. ISP was not developed to include hospice coordination of care from the hospice services start date of 10/09/14. 2. ISPs dated 03/05/15, 01/07/16, and 07/17/17 did not include hospice coordination of	A 026		

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A 026	Continued From page 18 care and were not signed by a LPN, RN, or PE. B. Record review of R #2's ISP revealed that the: 1. ISP was not developed to include hospice coordination of care from the hospice services start date of 07/17/17. 2. ISP dated 08/11/17 did not include hospice coordination of care and was not signed by a LPN, RN, or PE. C. On 09/14/17 at 4:32 pm, during an interview with the House Manager, she confirmed R #1's and R #2's ISPs were not updated and did not have a developed ISP for when hospice services began. The ISPs did not include coordination of care with hospice services, and the ISPs are not signed by an LPN, RN, or PE.	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	A 032		

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A 032	Continued From page 19 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] This REQUIREMENT is not met as evidenced by: 7.8.2.32. A B 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	A 032		

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A 032	Continued From page 20	A 032		

regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form.

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. That an internal investigation was conducted and a follow-up report was submitted within 5 business days to the Licensing Authority. This deficient practice has the potential for all 12 (R #s 1-12) listed on the resident census provided by the House Manager on 09/11/17 to be at risk of being abused, neglected, and/or not receiving needed medical care and services if incidents are not being reported as required. If the facility is not conducting internal investigations and submitting their findings to the Licensing Authority, then residents are at risk of continued suffering and further injury if there is no oversite of the care and services the facility is providing. The findings are:

Findings related to Incident Reports

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A 032	Continued From page 21 A. Record review of the internal Incident Reports for R #1, revealed there was no documentation that the following incidents were reported to the Licensing Authority: 1. On 04/07/16, R #1 had an unwitnessed fall (staff did not actually see the fall, but heard a load cry) with injury (2 skin tears to arm). 2. On 05/26/16, R #1 had an unwitnessed fall with injury to her nose (rug burn/scrape). 3. On 06/07/16, R #1 had an unwitnessed fall with injury to her nose (scrape). B. Record review of the internal Incident Report dated 10/30/16 for R #4, revealed there was no documentation that an incident of aggressive behavior (resident to resident abuse), resulting in the paramedics and police being called was reported to the Licensing Authority. C. Record review of the internal Incident Report dated 03/21/16 for R #6, revealed there was no documentation that an incident of an unwitnessed fall with injury (scrape on back) and anxiety requiring medication was reported to the Licensing Authority. D. Record review of the internal Incident Reports for R #9, revealed there was no documentation that the following incidents were reported to the Licensing Authority: 1. On 07/11/16, R #9 was found on the floor, unable to get up on her own, with a small bruise on her left side under her ribs. 2. On 09/24/16, R #9 was found with blood on her sheets/pillows and her wrist was swollen, red with an open wound/scratch on it. E. Record review of the Internal Incident Reports for R #10 revealed there was no documentation	A 032		

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A 032	Continued From page 22 that the following incidents were reported to the Licensing Authority: 1. On 12/18/16, R #10 had an incident of resident to staff abuse/aggressive behavior, when Direct Care Staff (DCS) #5 tried to redirect him out of another resident's room. R #10 put his arms around her [DCS] waist, gripped her wrists firmly, she feared he was going to throw her down, before DCS #2 was able to distract him. He calmed down after he took his medications. 2. On 12/22/16, R #10 had an unwitnessed fall with injury (carpet burn on arm). He was in his room alone after becoming upset when staff tried to assist him with taking off his pants. F. On 09/14/17 at 9:37 pm, during interview with the House Manager she confirmed that the reportable incidents for R #s 1, 4, 6, 9 and 10 were not reported to the Licensing Authority. Findings related to 5-day follow-up report G. Record review of the 5-day follow up report dated 10/31/16 (24-days late), for the self-report dated 09/19/16, for R #1, revealed that the 5-day follow-up report was not submitted to the Licensing Authority until after receiving notice of non-compliance during the survey on 10/19/16. H. On 09/14/17 at 2:05 pm, during interview with the House Manager, she confirmed that the follow-up report for R #1 was not submitted to the Licensing Authority within 5 business days after the incident and was 24-days late.	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	A 033		

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A 033	Continued From page 23 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 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;	A 033		

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A 033	Continued From page 24 (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; (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	A 033		

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A 033	Continued From page 25 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 (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 (10) Based on observation and interview the facility	A 033		

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A 033	Continued From page 26 failed to ensure the safety and welfare for 1 (R #2) of 1 (R #2) resident observed to have a physical restraint (full bedrail) in use. This deficient practice violates the residents right to not be physically restrained, prevents residents from freely getting in and out of bed, and could likely result in residents being injured if they get tangled up in the rails while attempting to climb around or over them to get out of bed. The findings are: A. On 09/13/17 at 10:00 am, during observation of resident room #4, a physical restraint (full bedrail) was observed to be in use while R #2 was in bed. B. On 09/14/17 at 7:20 am, during observation of resident room #4, a the full bed rail was observed to be in use (up position) while R #2 was in bed. C. On 09/14/17 at 7:25 am, during interview with Direct Care Staff (DCS) #1, she confirmed that a physical restraint (full bedrail) was being used for R #2 while in bed. D. Record review of R #2's physician's orders revealed that there was no order for the use of a bedrail (any size) available for review. E. On 09/14/17 at 9:37 am, during interview with the House Manager, she confirmed that there was no physician's order available for review for the use of bedrail's (any size) for R #2 available for review.	A 033		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to	A 034		

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A 034	Continued From page 27 this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used	A 034		

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A 034	Continued From page 28 for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the	A 034		

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A 034	Continued From page 29 administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (4) (7) (8) B (2) Reference NFPA 99 (Healthcare Facilities Code) 2012 Edition NFPA 99. 11.3 Cylinder and Container Storage Requirements. 11.3.1* Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or	A 034		

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A 034	Continued From page 30 within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. 11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. 11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1?2 hour 11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations.	A 034		

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A 034	Continued From page 31 11.3.2.8 Cylinder valve protection caps shall comply with 11.6.2.3. 11.3.2.9 Gas cylinder and liquefied gas container storage shall comply with 5.1.3.5.12. 11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 11.3.3.1 and 11.3.3.2. 11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not be required to be stored in enclosures. 11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. 11.3.3.3 When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders. 11.3.3.4 Individual small-size (A, B, D, or E) cylinders available for immediate use in patient care areas shall not be considered to be in storage. 11.3.3.5 Cylinders shall not be chained to portable or movable apparatus such as beds and oxygen tents. 11.3.4 Signs. 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following	A 034		

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wording as a
minimum:
CAUTION:
OXIDIZING GAS(ES) STORED WITHIN
NO SMOKING
2012 Edition

Based on observation and interview, the facility failed to ensure that:
1. Medications were being labeled, dated, and stored correctly.
2. Medications for each resident was being stored in separate compartments and was labeled with each resident's name.
3. That the narcotic proof of use record sheets were available, complete and balanced with the actual narcotic count.
4. There was a system of records and disposition used to make an accurate reconciliation of all medications.
5. Only oxygen cylinder tanks needed for immediate use were being stored in resident rooms and that they were stored in a well ventilated area, away from combustibles (facility records, clean linens, pictures etc.).
6. "Oxygen in Use" signs were posted outside the rooms of residents on oxygen.

These deficient practices have the potential for the safety and welfare of all 12 (R #s 1-12) residents listed on the resident census, provided by the House Manager (HM) on 09/11/17, to be at risk if:
1. Medications are not labeled, dated, and stored correctly and they receive the wrong medication, wrong dose, at the wrong time, or take medications that are no longer effective.
2. The narcotic count, shift count, and control log are not available, accurate, and complete.
3. A system of the receipt and disposition of

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all drugs is not in place to enable accurate reconciliation.
4. An oxygen cylinder tank were to become missile or fuel a fire and there are no "oxygen in use" signs as a warning, then residents are at an increased risk of harm or death if a fire were to occur.

The findings are:

Findings related to narcotic medications:

A. On 09/14/17 at 11:40 am, during observation with the Administrator and HM, bottle #1 of Lorazepam/Ativan could not be located and bottle #2 of Lorazepam/Ativan was observed to only have 19 mls (milliliters) remaining.

B. Record review of R #6's Narcotic Proof of Use sheet for Lorazepam/Ativan (agitation) for bottle #1, revealed that on 06/29/17 there should have been 4.75 mls (milliters) remaining.

C. Record review of R #6's Narcotic Proof of Use sheet for Lorazepam/Ativan, for bottle #2 (still in use), revealed that on 09/13/17 there should have been 22 mls remaining.

D. On 09/14/17 at 11:40 am, and 2:13 pm, during interviews with the Administrator and HM:
1. The HM stated that on 07/01/17, bottle #1 was empty, she noted as discontinued, and threw the bottle away (4.75 mls unaccounted for).
2. Confirmed that the amount remaining in bottle #2 was 19 mls (3 mls unaccounted for).
3. Confirmed that a total of 7.75 mls of R #6's Lorazepam/Ativan was unaccounted for.

Findings related to Daily Narcotic Count Logs/Shift Count Sheets:

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E. Record review of R #6's Narcotic Count Logs dated 02/13/17 thru 07/01/17 for Lorazepam/Ativan for bottle #1, revealed that the Direct Care Staff (DCS) [Name unknown] who assisted R #6 with her Lorazepam/Ativan, incorrectly documented doses given (40 times) on the Narcotic Count Logs/Shift Count Sheets instead of on the Proof of Use Sheets making an accurate reconciliation of the narcotic medication difficult.

F. On 09/14/17 at 11:40 pm, and 2:13 pm, during interviews with the Administrator and HM, they confirmed that the DCS [Names unknown] who assist residents with the self-administration of medications were incorrectly documenting doses given on the Narcotic Count Logs/Shift Count Sheets instead of on the Proof of Use sheets making an accurate reconciliation of the narcotic medication difficult. The Administrator also confirmed that the aides who have been drawing the medication into the syringe for the residents are not licensed nurses.

Findings related to medication storage/labeling:

R #2 :

G. On 09/14/17 at 10:12 am, during observation of the medication cart the following was observed for R #2:

1. The medication card for Entacapone/Comtan (Parkinson's) 200 mgs (milligrams) indicated take 1 tablet by mouth and did not match his September 2017 MAR, which stated take 1 tablet by mouth twice daily. The observation was confirmed by the HM.

2. One 8.3 oz (ounce) bottle of Flu Relief Therapy (cold and chest congestion) was not

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labeled with his name on it. The observation was confirmed by the HM.

3. One bottle (59 pills remaining) of Tylenol/Acetaminophen 500 mgs (milligrams) (quanity 60) was observed in the cart. R #2's September MARs and physician orders dated 07/17/17 stated Acetaminophen 325 mgs. The observation was confirmed by the HM.

H. On 09/14/17 at 10:28 am, during interview with the HM, she confirmed the missing and incorrect labels on R #2's medication cards.

R #4:

I. On 09/14/17 at 10:12 am, during observation of the mediation cart the following was observed for R #4:

1. The medication card for Warfarin/Coumadin (blood thinner) 3 mg stated take 1 tablet by mouth daily except Sunday and did not match her September 2017 MAR and physician's order dated 09/12/17 stated take 1 tablet by mouth daily in the evenings Monday-Friday.

2. The medication card for Diltiazem (Hypertension) 120 mg (microgram) stated take 1 tablet by mouth 3 times a day and did not match her September 2017 MAR and physician's orders dated 01/09/17 that stated take 1 tablet by mouth daily.

J. On 09/14/17 at 11:25 am, during interview with the HM, she confirmed the labels on the medication cards for R #4 were incorrect and stated the cards needed to be updated.

R #s 5 and 11:

K. On 09/14/17 at 10:12 am, during observation

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of the medication cart, R #11's Lantus/Insulin (diabetes) pens (2) were observed to not be labeled with his name and were not dated when opened.

L. On 09/14/17 at 10:12 am, during observation of the medication cart, R #8's Humalog/Insulin (diabetes) pen was observed to not be dated when opened.

M. On 09/14/17 at 10:15 am, during interview with the HM, she confirmed that R #s 5 and 8 insulin pens were not dated when opened and R #5's pen was not labeled with his name.

Findings related to medications stored in the medication refrigerator:

N. On 09/14/17 at 10:12 am, during observation of the medication refrigerator, R #4's eyedrops and R #8's insulin were observed to be stored in the same basket.

O. On 09/14/17 at 10:20 am, during interview with the HM, she confirmed that R #4's eyedrops and R #8's insulin were being stored in the same basket.

Findings related to topical medication storage:

P. On 09/14/17 at 10:12 am, during observation of the medication cart the following topical medications were observed to be stored together in the same basket.
1. R #2's Erythromycin/Ilotycin (eye infections) ointment.
2. R #5's First Aid Ointment (Bacitracin) for ringworm.
3. R #8's Mupirocin/Bactroban ointment (antibiotic).

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A 034	Continued From page 37 4. R #9's Hydroskin/1% Hydrocortisone lotion (steroid itching/redness). 5. R #11's. Estradiol/Climara patch (1) (Hormone replacement). Q. On 09/14/17 at 11:30 am, during interview with the HM, she confirmed that R #s 2, 5, 8, 9 and 11's topical medications were all being stored together in the same basket. Findings related to oxygen storage and signs: R. On 09/11/17 at 2:58 pm, during observation, 4 tall oxygen cylinder tanks (secured) were observed being stored in room #12 between the resident's bed and a wooden night stand. S. On 09/12/17 at 1:35 pm, during observation of the clean linen closet 1 tall oxygen cylinder tank (secured) was observed being stored in the clean linen closet surrounded by combustible (clean linens, cleaning supplies, facility records/files, picture frames, light bulbs) items. T. On 09/12/17 at 1:49 pm, during interview with the House Manager (HM), she confirmed that the oxygen cylinder tank was being stored in the clean linen closet surrounded by combustible items. U. On 09/12/17 at 1:55 pm, during interview with the HM, she confirmed that the 4 tall (secured) oxygen cylinder takes being stored in Rm #12 between the resident's bed and a wooden table. V. On 09/12/17 at 2:07 pm, during observation and interview with the Administrator, she confirmed that there were no "oxygen in use" signs posted outside the doors of resident room #s 3 and 12.	A 034		

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A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP.	A 035		

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A 035	Continued From page 39 D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given;	A 035		

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A 035	Continued From page 40 (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name;	A 035		

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(2) the name of the medication;
(3) the date that the prescription was issued;
(4) the prescribed dosage and the instructions for administration of the medication; and
(5) the name and title of the prescriber.
L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery.
M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record.
N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED).
[7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.35 A D G (2) (3) (17)

Based on record review, observation, and interview the facility failed to ensure that:
1. Only licensed nurses (LN) or certified health care providers (CHCP) administer medications to residents who cannot assist with the self-administration of medication and assess the need for, when given, and the amount of PRN (as needed) medications are given.
2. Physician orders for the use of oxygen and bedrails were obtained and on file in the resident's chart.
3. The Medication Administration Records (MARs) were accurate, complete and contained

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A 035	Continued From page 42 all required information. These deficient practices have the potential to to cause serious illness or injury requiring emergency medical treatment and even death to the 12 (R #s 1-12) residents listed on the resident census, provided by the House Manager (HM) on 09/11/17 if: 1. Unlicensed/non-qualified Direct Care Staff (DCS) incorrectly administer medications to residents that are not cognitively or physically able to assist with the self administration of their medications and make incorrect assessments of the need for, when given, and amount of PRN medications to be given. 2. Physician orders are not obtained to ensure the physical restraints and oxygen are only being used under the direction and supervision of the physician. 3. Medication errors occur because the MARs are not accurate, complete and contained all required information. The findings are: Findings related to the administration of medications/assessment of PRNs: A. On 09/12/17 at 11:10 am, during observation of the medication pass for R #5, DCS #1 was observed to have to put the cup of pills up to his mouth, pour the pills into his mouth, and remind him to swallow them. B. On 09/12/17 at 11:11 am, during interview with DCS #1, she confirmed that R #5 was not able to assist with the self-administration of his medication (physically or cognitively). She stated that if they give him the cup of pills he will just play with them, that he needs his medications administered and that she is not a nurse.	A 035		

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A 035	Continued From page 43 C. Record review of R #2's 09/01/17 to 09/14/17 MAR revealed the current orders for the following PRN medications require an assessment of both need for and amount given to be made prior to being given/taken: 1. Lorazepam/Ativan (anxiety) 2 mg/ml (milligrams/milliliters): Give 0.25 to 1 ml orally every 4-6 hours as needed for anxiety. 2. Morphine Sulfate/Roxanol (pain) 20 mg/ml (milligrams/milliliters): Give 0.2 to 1 ml orally every 1-4 hours as needed for pain and shortness of breath. D. On 09/14/17 at 10:38 am, during interview with the House Manager and Administrator, they confirmed that the Direct Care Staff who assist residents with medications are not qualified to assess and make decisions regarding the need for and amount of medication to be given. Findings related to physician orders (bedrails/oxygen): Findings related to R #2 E. On 09/13/17 at 10:00 am, during observation resident room (rr#4), a full bedrail was observed to be in the up position while R #2 was in bed. F. On 09/14/17 at 7:20 am, during observation of rr #4, a full bedrail was observed to be in use (up position) while R #2 was in bed. G. On 09/14/17 at 7:25 am, during interview with DCS #1, she confirmed that a full bedrail was being used for R #2 while in bed. H. Record review of R #2's physician's orders [undated] revealed that there was no order for the use of a bedrail (any size) available for review.	A 035		

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A 035	Continued From page 44 I. On 09/14/17 at 9:37 am, during interview with the House Manager, she confirmed that there was no physician's order available for review for the use of bedrail's (any size) for R #2. Findings related to R #3 J. On 09/12/17 at 2:07 pm, during observation of rr #3, an oxygen concentrator for R #3 was observed. The observation was confirmed by the Administrator. K. Record review of R #3's physician orders [undated], revealed that there was no order for the use of oxygen available for review by the Licensing Authority. L. On 09/14/17 at 4:56 pm, during interview with the House Manager, she confirmed the R #3 did use oxygen PRN (as needed) and the facility did not have a physician's order for R #3's oxygen. Findings related to R #6 M. On 09/13/17 at 10:00 am, during observation of rr #1, bedrails (quarter) were observed in use (up-position) while R #6 was in bed. N. Record request for R #6's physician's order for the bedrails, revealed that there was no order for the use of bedrails (quarter) available for review by the Licensing Authority. O. On 09/14/17 at 4:56 pm, during interview with the House Manager, she confirmed that the facility did not have physician orders for the use of bed rails (quarter) for R #6. Findings related to R #7	A 035		

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P. On 09/13/17 at 10:00 am, during observation of rr #12, bedrails (quarter) were observed in the use (up-position) while R #7 was in bed.

Q. Record request for R #7's physician's order for the bedrails, revealed that there was no order for the use of bedrails (quarter) available for review by the Licensing Authority,

R. On 09/14/17 at 4:56 pm, during interview with the House Manager, she confirmed that the facility did not have physician orders for the use of bed rails (quarter) for R #7.

Findings related to MARs

Findings related to R #2

S. Record review of R #2's 09/01/17 to 09/14/17 MAR revealed the following:
1. Name/Contact information for Physician.
2. Initals missing for DCS [name unknown] who assisted with medications for 9:00 pm doses of Entacapone F/C/Comtan (Parkinson's Disease) on 09/05/17, 09/06/17, 09/12/17, and 09/13/17.
3. There was no documentation of why R #2 did not take the 9:00 pm doses of Entacapone F/C/Comtan (Parkinson's Disease) on 09/05/17, 09/06/17, 09/12/17, and 09/13/17.
4. Tylenol/Acetaminophen 500 mg (milligram) is missing from the MAR. The medication was in the medication cart, when counted there was 59 of 60 pills (1 taken) remaining. There was no physician's order available for review by Licensing Authority.

T. Record review of the Medication Detail Report, dated 08/31/17 to 09/14/17 revealed no

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A 035	Continued From page 46 documentation of why R #2 did not take his 9:00 pm doses of Entacapone F/C/Comtan (Parkinson's Disease) on 09/05/17, 09/06/17, 09/12/17, and 09/13/17. Findings related to R #3 U. Record review of R #3's 09/01/17 to 09/14/17 MAR revealed the following: 1. No physician name/contact information on MAR. 2. No documentation of known or unknown allergies. 3. No physician's order for oxygen listed on the MAR. 4. Acetaminophen 500 mg take 1-2 tablets by mouth every 6 hours as needed for pain. There was no Physician's order for this medication available for review by the Licensing Authority. 5. MAR states Hydroco/APAP 5-325 mg (Hydrocodone 5 mg-Acetaminophen 325 mg) (pain relief) states take 1-1.5 tablet once daily for pain. There was no Physician order or discontinue order found. 6. No results for PRN medications. V. Record review of R #4's 09/01/17 to 09/14/17 MAR revealed the following: 1. No physician name/contact information on the MAR. 2. No documentation of results for PRN medications. W. On 09/14/17 at 4:56 pm, during interview with the House Manager, she confirmed the findings listed above for R # 2-4's MARs.	A 035		
A 036	7 NMAC 8.2.36 Nutrition	A 036		

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A 036	Continued From page 47 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 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	A 036		

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A 036	Continued From page 48 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 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.	A 036		

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A 036	Continued From page 49 (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 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.	A 036		

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A 036	Continued From page 50 (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 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,	A 036		

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A 036	Continued From page 51 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 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	A 036		

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A 036	Continued From page 52	A 036		

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) (d), B (1) (4), C (1) (c) (2) (c) (d) (5), D (2) (b) (3) (7)

Based on observation, interview, and record review the facility failed to ensure that:
1. A daily log of the recorded temperatures for the refrigerators/freezers were maintained.
2. A monthly log of periodic monitoring of the dishwasher temperatures were conducted, documented and maintained.
3. Hairnets/caps were worn when staff was preparing food.
4. That the kitchen floors and cupboards were kept clean, pest free, good repair, and maintained in a safe and sanitary manner.
5. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days.
6. The menu was posted where residents/families/visitors could easily view it and that it included snacks.

This deficient practice has the potential to cause all 12 (R #s 1-12) residents listed on the resident census, provided by the House Manager (HM) on 09/11/17 to be at risk of:
1. Contracting foodborne illnesses if :

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF FARMINGTON	**400 NORTH LOCKE ST FARMINGTON, NM 87401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 036	Continued From page 53 a. Food is not stored properly, maintained and served at the proper temperatures b. Dishwasher temperatures are not check periodically and recorded to ensure the dishes are being cleaned and sanitized at the correct temperatures to kill germs and bacteria. c. While being prepared food becomes contaminated with staff hair and germs. d. The kitchen floors and cupboard areas are not kept clean, free of pests, good repair, and maintained in a clean and sanitary environment. 2. Not being able to have a choice of food and mealtime/snacks, because they do not know what food/snacks are being served each day. The findings are: Findings related to temperature logs: A. Record review of the freezer/refrigerator logs revealed that there were no daily recording of temperatures (only weekly) and there had been no temperatures recorded for the refrigerator since week 4 in August 2017 (not dated) and for the freezer since 08/15/17. B. On 09/12/17 at 11:18 am, during observation the temperature in the freezer was observed to not be maintained at 0 degrees Fahrenheit (F) or below. Temperature reading with surveyors thermometer was observed to be 5 degrees Fahrenheit (F), the reading on the freezer thermometer was 25 degree F. C. On 09/12/17 at 11:19 am during interview with Direct Care Staff (DCS #1), she confirmed the freezer temperature was not maintained at 0 degrees F. In addition, she confirmed the temperature readings with surveyors thermometer was 5 degrees F and the temperature reading on the freezer thermometer was 25 degree F.	A 036		

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A 036	Continued From page 54 D. Record request for the monthly dishwasher temperature logs revealed that there were no logs available for review by the Licensing Authority. E. On 09/13/17 at 10:51 am, during interview with the Cook, she confirmed that there were no dishwasher temperature logs available for review. In addition she stated that she did not know that she was supposed to be taking the dishwasher temperatures. The Cook also confirmed that at this time there were no test strips available to ensure the dishwasher was sanitizing the dishes at the proper level. Findings related to hairnets/caps: F. On 09/12/17 at 9:14 am, during observation, the Cook was observed to not be wearing a hairnet while preparing breakfast. G. On 09/12/17 at 9:15am, during interview with the Cook, she confirmed that she was not wearing a hairnet while preparing breakfast this morning, she also stated that she did not know she needed to or that hairnets were available to use. Findings related to kitchen floors: H. On 09/12/17 at 10:00 am, during observation of the kitchen floor it was observed to be dirty, sticky, with dirt/grease buildup around the edges. I. On 09/13/17 at 11:25 am. during interview with the Cook, she confirmed that the kitchen was dirty, sticky, with dirt/grease buildup around the edges. Findings related to kitchen cupboards:	A 036		

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A 036	Continued From page 55 J. On 09/13/17 at 10:54 am, during observation of an unlocked kitchen cupboard next to the ice maker was observed to: 1. Have an opening/separation in back of the cupboard allowing for possible /rodent infestation. 2. Be dusty/dirty with 7-dirty/dusty plastic water pitchers, old newspaper, flowers, flower vase scattered in it. K. On 09/13/17 at 11:00 am, during interview with the Cook, she confirmed that the cupboard was dirty/dusty with 7-dirty/dusty plastic water pitchers, old newspaper, flowers, flower vase scattered in it and had an opening/separation in the back allowing for possible pest/rodent infestation. L. On 09/13/17 at 11:02 am, during observation of the kitchen cupboard next to the refrigerator it was observed to be dirty with an unsealed opening around the waterline allowing for possible pest/rodent infestation. M. On 09/12/17 at 11:04 am, during interview with the Cook, she confirmed that the cupboard next to the refrigerator was dirty and had an unsealed opening around the waterline allowing for possible pest/rodent infestation. N. On 09/13/17 at 11:05 am, during observation of the cupboard drawers (2 by stove, 1 by dishwasher) where eating/cooking utensils, straws, napkins, ect..used by residents and to prepare food were observed to be dirty/dusty, and to have insect dropping in it. O. On 09/13/17 at 11:25 am, during interview with the Cook, she confirmed that the kitchen	A 036		

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A 036	Continued From page 56 drawers were dusty/dirty and had insect dropping in them. Findings related to food storage/cleanliness of the freezer/refrigerator/pantry: P. On 09/12/17 at 10:02 am, during observation of the freezer, the following was observed: 1. 1 baggie with 2 unknown meat patties, sealed, not dated or labeled when packaged. 2. 2 baggies with ground beef, sealed, not dated or labeled when packaged. 3. 1-11.5 oz (ounce) package of pizzas, not dated or labeled when opened. 4. 1-10 oz package of pie crusts, used, not sealed (exposed), not dated or labeled when opened. 5. 1-5 lb (pound) package of bread dough, used, not sealed, not dated or labeled when opened. 6. 1-3 lb box of sausage links, used, not sealed (exposed), not dated or labeled when opened. 7. 2-32 oz packages of Chimichangas, used, not sealed (exposed), not dated or labeled when opened. 8. 1-3 lb package of chicken patties, used, not dated or labeled when opened. 9. 1 package of sugar free popcicles, not sealed, not dated or labeled when opened. 10. 1-1 gallon container of sherbet, used, not dated or labeled when opened. 11. Inside of freezer was observed to be dirty and had ice build-up on the ceiling. Q. On 09/12/17 at 10:18 am, during interview with the House Manager (HM), she confirmed the food storage findings listed above and that the freezer was dirty and had ice build-up on the ceiling.	A 036		

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A 036	Continued From page 57 R. On 09/12/17 at 10:25 am, during observation of the refrigerator, the following was observed: 1. 1 package of red grapes, used, not sealed, not dated or labeled when opened. 2. 1-16 oz package of strawberries, used, not dated or labeled when opened, mold. 3. 1-container of leftover fruit cocktail, used, not dated or labeled when put in the refrigerator. 4. 1 cantaloupe, used, sealed, not dated or labeled. 5. 1 package of green grapes, used, not sealed, not dated or labeled when opened. 6. 2-32 count crates of fresh eggs, not dated or labeled when received. 7. 1-21 count crate of fresh eggs, not dated or labeled when received. 8. 1-24 oz package of fresh mushrooms, used, not dated or labeled when opened. 9. 1 bowl of leftover chocolate pudding not dated or labeled when put in refrigerator. 10. 1-30 oz bottle of grape jelly, not dated or labeled when opened. 11. 1-6 oz package or pepperoni slices, used, not dated or labeled when opened. 12. 1-8 oz package of hard salami slices, used, not dated or labeled when opened. 13. 1-24 oz package of string cheese, used, not dated or labeled when opened. 14. 1-40 oz package of string cheese, used, not sealed, not dated or labeled when opened. 15. 1-16 oz package of ham slices, used, not dated or labeled when opened. 16. 1-32 oz package of shredded cheese, used, not dated or labeled when opened. 17. 1-32 oz container of heavy cream, used, not dated or labeled when opened. 18. 1-46 oz jar of applesauce, used, not dated or labeled when opened.	A 036		

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A 036	Continued From page 58 S. On 09/12/17 at 10:45 am, during interview with the cook, she confirmed the food storage findings in the refrigerator. T. On 09/12/17 at 10:48 am, during observation of the the food pantry (right side), food items (potatoes, onions,) were observed to not be stored 6 inches off the floor. The flour and sugar containers were observed to not be sealed, open to the environment. U. On 09/12/17 at 10:49 am, during interview with DCS #1, she confirmed that the food items in the pantry (right side) listed were not stored 6 inches off the floor and the flour and sugar containers were not sealed, open to the environment. V. On 09/13/17 at 11:20 am, during observation of the pantry (left side) the following items on the bottom shelf were observed to not be stored 6 inches off the floor. 1. 1-128 oz bottle of pancake syrup. 2. 1-12.8 oz box of 12-8oz bottles of boost. 3. 1-2 liter bottle of ginger ale. 4. 1-96 oz bottle of vegetable oil. 5. 1-16 oz box of barley, used, not sealed, exposed to environment. W. On 09/13/17 at 11:25 am, during interview with the Cook, she confirmed that the above listed items in the pantry were not stored 6 inches off the floor. Findings related to menus: X. Record review of the past 30-days of menus revealed there were no snacks listed on the menu.	A 036		

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A 036	Continued From page 59 Y. Record request for documentation of the past 30 days of menus as served, including snacks, revealed there were no menus available for review by the Licensing Authority. Z. On 08/13/17 at 8:56 am, during observation of the weekly menu it was observed to not be posted where residents, family, friends could easily view it. AA. On 09/13/17 at 8:58 am, during interview with the HM, she confirmed that the week menu menus did not include snacks and was not posted where everyone could view it. In addition she confirmed that no documentation of the past 30-days of menus as served including snacks available for review. BB. On 08/13/17 at 8:58 am, during interview with the HM, she confirmed that the menus did not include snacks and was not posted where everyone could easily view it.	A 036		
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of	A 037		

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A 037	Continued From page 60 infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet. B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (10)	A 037		

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A 037	Continued From page 61	A 037		

Based on observation and interview the facility failed to ensure that cleaning supplies were:
1. Not being stored with clean linens.
2. Kept in a secure room or cabinet and not accessible to residents.

These deficient practice has the potential for all 12 (R #s 1-12) residents listed on the resident census, provided by the House Manager on to be a risk of illness, harm, or injury if the:
1. Cleaning supplies and chemicals are spilt and absorbed by the clean linens, that could make residents ill or fuel if a fire were to occur.
2. Cleaning supplies are accidentally spilled on the floor or residents, consumed by residents, or if become fuel if a fire were to occur. The findings are:

A. On 09/12/17 at 1:35 pm, during observation of the clean linen closet the following was observed:
1. The cleaning cart with the following cleaning supplies was observed being stored in the clean linen closet:
A. 1-32 oz (ounce) bottle of surface cleaner.
B. 1-14.2 oz can of furniture polish.
C. 1-32 oz bottle of pine cleaner.
D. 1-32 oz bottle of disinfectant.
E. 1-8.8 oz can of air freshener.
F. 1-9.1 oz plastic container of bleach wipes.
G. 1-32 oz bottle of sanitizer.
H. 1-28 oz of powder cleaner.
I. 1-32 oz bottle of window cleaner.
J. 1-8 oz bottle of air freshener.
K. 1 large tub with powdered laundry soap.

B. On 09/12/17 at 1:49 pm, during interview with

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A 037	Continued From page 62 the House Manager, she confirmed the cleaning cart with the above listed cleaning supplies on it was being stored in the linen closest. C. On 09/13/17 at 10:54 am, during observation of an unlocked kitchen cupboard next to the ice maker accessible to residents (with dementia and memory loss) the following cleaning/flammable supplies were observed: 1. 1-28 oz bottle of liquid hand soap. 2. 1-32 oz bottle of drain cleaner. 3. 2-1 lb (pound)-45 oz containers of bleach wipes. 4. 1-32 oz bottle of charcoal lighter fluid. D. On 09/13/17 at 11:00 am, during interview with the Cook, she confirmed that the cleaning/flammable supplies were stored in the unlocked kitchen cupboard and accessible to residents. E. On 09/13/17 at 11:02 am, during observation of an unlocked kitchen cupboard next to the refrigerator accessible to residents (with dementia and memory loss) 1-32oz bottle of table sanitizer was observed. F. On 09/13/17 at 11:04 am, during interview with the Cook, she confirmed that the table sanitizer was stored in the unlocked cupboard in the kitchen next to the refrigerator and accessible to residents. G. On 09/13/17 at 11:12 am, during observation of an unlocked kitchen cupboard under the sink accessible to residents (with dementia and memory loss), the following was observed: 1. 1-13 gallon box of tall kitchen garbage bags. 2. 1-121 oz bottle of bleach.	A 037		

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A 037	Continued From page 63 3. 1-155 oz bottle of dishwashing detergent. 4. 1-90 oz bottle of liquid dish soap. 5. 1-1 gallon bottle of dish soap. 6. 1-32 oz bottle of vinegar. 7. 1-240 oz can of leftover cooking grease. 8. 1 box of 2 eraser cleaning pads. 9. 1-1.4 oz package of garbage disposal cleaner. 10. 1-4 oz bottle of machine oil. H. On 09/13/17 at 11:25 am, during interview with the Cook, she confirmed that the above listed cleaning/flammable supplies were stored in the kitchen cupboard under the sink and accessible to residents	A 037		
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to	A 038		

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A 038	Continued From page 64 state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.38 A, B, C Based on observation and interview the facility failed to ensure that: 1. The kitchen and fuel-fired heater/hot water room was kept clean, free of safety hazards, insects. 2. Poisonous combustible cleaning supplies and flammable materials were not stored in resident and food preparation area. 3.The cleaning supplies and flammable materials should be stored in an approved closed metal cabinets in the well ventilated area. This deficient practice has the potential for all 12 (R #s 1-12) residents listed on the census, provided by the House Manager on 09/11/17 to be at risk of illness, injury, and/or death if: 1. They were to fall on the dirty, sticky, greasy floor of the kitchen. 2. They were to contract foodborne illnesses from consuming food or using utensils and other items (straws, napkins, ect..) contaminated with bacteria/germs/disease from dirt/dust/insect droppings. 3. Poisonous, combustible cleaning supplies/flammable chemicals ignite/fuel a fire and dangerous vapors spread throughout the building. 4. There is dirt/dust/rubbish on the floor around the fuel-fired heater and hot water heater that could ignite/fuel a fire.	A 038		

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A 038	Continued From page 65 The findings are: Findings related to trash can and floors A. On 09/12/17 at 10:00 am, during an observation of the kitchen the trash can was observed to be very dirty and the floor was dirty, sticky, with dirt/grease buildup around the edges. B. On 09/13/17 at 11:25 am, during an interview with the Cook she confirmed that the kitchen trash can was dirty and the floor was dirty, sticky, with grease buildup around the edges. Findings related to cleaning supplies/flammable chemicals and cleanliness. C. On 09/12/17 at 1:35 pm, during an observation of the clean linen closet the following was observed: 1. Observed that the cleaning cart with the following cleaning supplies being stored in the clean linen closet: a. 1-32 oz (ounce) bottle of surface cleaner. b. 1-14.2 oz can of furniture polish. c. 1-32 oz bottle of pine cleaner. d. 1-32 oz bottle of disinfectant. e. 1-8.8 oz can of air freshener. f. 1-9.1 oz plastic container of bleach wipes. g. 1-32 oz bottle of sanitizer. h. 1-28 oz of powder cleaner. i. 1-32 oz bottle of window cleaner. j. 1-8 oz bottle of air freshener. k. 1 large tub with powder laundry soap. 2. The clean linen closet was observed to be used for storage of facility records/files, 2 boxes of long light bulbs, wheel chair parts, pictures, 1 tall oxygen cylinder tank, etc.	A 038		

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A 038	Continued From page 66 D. On 09/12/17 at 1:49 pm, during an interview with the House Manager, she confirmed the observation that the poisonous, combustible cleaning supplies/flammable chemicals were being stored in the clean linen closet along with facility records/file, light bulbs, wheelchair parts, pictures, oxygen cylinder tank, etc. E. On 09/12/17 at 2:30 pm, during an observation of fuel-fired heater/hot water heater room was observed to be dirty/dusty, and to have rubbish on the floor. F. On 09/12/17 at 3:23 pm, during an interview with the Maintenance Director and Maintenance Assistant they confirmed that the fuel-fired heater/hot water heater room was dirty/dusty and had rubbish on the floor. G. On 09/13/17 at 10:54 am, during an observation of an unlocked kitchen cupboard next to the ice maker accessible to residents (with dementia/memory loss) the following was observed: 1. The following poisonous, combustible cleaning supplies/flammable chemicals were observed: a. 1-28 oz bottle of liquid hand soap. b. 1-32 oz bottle of drain cleaner. c. 2-1 lb (pound)-45 oz containers of bleach wipes. d. 1-32 oz bottle of charcoal lighter fluid. 2. The cupboard was observed to be dirty/dusty with plastic water pitchers, old newspaper, flowers, and a flower vase all scattered about in the cupboard. H. On 09/13/17 at 11:00 am, during an interview with the Cook, she confirmed that the poisonous,	A 038		

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A 038	Continued From page 67	A 038		

combustible cleaning supplies/flammable chemicals were being stored in the cupboard. In addition she confirmed that the cupboard was dirty/dusty with plastic water pitchers, old newspaper, flowers, and a flower vase all scattered about in the cupboard and accessible to residents.

I. On 09/13/17 at 11:02 am, during an observation of the kitchen cupboard next to the refrigerator it was observed to be dirty and had 1-32 oz bottle of table sanitizer stored in it accessible to residents (with Dementia/memory loss).

K. On 09/12/17 at 11:04 am, during an interview with the Cook, she confirmed that the cupboard next to the refrigerator it was observed to be dirty and had 1-32 oz bottle of table sanitizer stored in it accessible to residents (with Dementia/memory loss).

L. On 09/13/17 at 11:05 am, during observation of the cupboard drawers where eating/cooking utensils, straws, napkins, etc, used by residents and used to prepare food were observed to be dirty/dusty, and to have insect droppings.

M. On 09/13/17 at 11:12 am, during observation of an unlocked kitchen cupboard under the sink accessible to residents (with Dementia/memory loss) the following poisonous, combustible/flammable cleaning supplies and chemicals were observed:

1. 1-13 gallon box of tall kitchen garbage bags (flammable).
2. 1-121 oz bottle of bleach
3. 1-155 oz bottle of dishwashing detergent.
4. 1-90 oz bottle of liquid dish soap.
5. 1-1 gallon bottle of dish soap.

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A 038	Continued From page 68 6. 1-32 oz bottle of vinegar 7. 1-240 oz can of leftover cooking grease. 8. 1 box of 2 eraser cleaning pads. 9. 1-1.4 oz package of garbage disposal cleaner. 10. 1-4 oz bottle of machine oil. N. On 09/13/17 at 11:25 am. during an interview with the Cook, she confirmed that the kitchen drawers were dusty/dirty and had insect droppings in it. In addition she confirmed that the above listed poisonous, combustible cleaning supplies/flammable material were being stored in the unlocked kitchen cupboard under the sink accessible to residents (with Dementia/memory loss).	A 038		
A 043	7 NMAC 8.2.43 Hazardous Areas HAZARDOUS AREAS: Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than one hundred (100) sq. ft., storage rooms more than fifty (50) sq. ft. but less than one hundred (100) sq. ft. not storing combustibles, storage rooms with more than one hundred (100) sq. ft. storing combustibles, chemical storage rooms with more than fifty (50) sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either: (1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter (3/4) hour rating; or (2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke	A 043		

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A 043	Continued From page 69 detection; or (3) other hazardous areas shall be enclosed with walls with at least a twenty (20) minute fire rating and doors equivalent to one and three-quarter (1 3/4) inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. Boiler, furnace or fuel fired water heater rooms. For facilities with four (4) or more residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one (1) hour. Doors to these rooms shall be one and three-quarter (1-3/4) inch solid core. [7.8.2.43 NMAC - Rp, 7.8.2.44 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.43 B Based on observation and interview, the facility failed to ensure that: 1. Ceiling entry to the attic from the clean linen closet was protected/covered to prevent smoke and flame penetration into the attic creating a hazardous area. 2. Drywall penetrations/holes in the fuel-fired furnace room (hazardous area) were properly sealed with approved fire suppression material and the vent extended through the attic to the outside. This deficient practice has the potential for all all 12 (R #s 1-12) residents listed on the resident census, provided by the House Manager on 09/11/17, staff, and visitors to be at an increased risk of harm, injury, or death from smoke, vapors, and flames spreading faster through the attic, because if was not properly	A 043		

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A 043	Continued From page 70 protected. The findings are: A. On 09/12/17 at 1:35 pm, during an observation of the clean linen closet, the ceiling cover panel for the attic was observed to be missing, allowing for penetrations of smoke, vapors, and flames, if a fire were to occur. B. On 09/12/17 at 1:49 pm, during interview with the House Manager, she confirmed that the ceiling cover panel for the attic was missing allowing for penetrations of smoke, vapors, and flames, if a fire were to occur. C. On 09/12/17 at 2:30 pm, during an observation of the furnace room, penetrations (holes) in the drywall were observed and the vent was observed to not extend/protect all the way to the outside allowing for smoke, vapor, and flame penetration into the attic if a fire were to occur. D. On 09/12/17 at 3:23 pm, during an interview with the Maintenance Director and Maintenance Assistant, they confirmed the observation of the drywall penetrations and that the vent did not extend to the outside, allowing for smoke, vapor, and flame penetration into the attic if a fire were to occur.	A 043		
A 044	7 NMAC 8.2.44 Heating, Air-Conditioning and Ventilation HEATING, AIR-CONDITIONING AND VENTILATION: A. Heating, air-conditioning, piping, boilers and ventilation equipment shall be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities shall have	A 044		

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A 044	Continued From page 71 documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. B. The heating method used by the facility shall provide a minimum temperature of seventy (70) degrees fahrenheit, measured at three (3) feet above the floor, in all rooms used by the residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device shall be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances shall be permanently anchored and kept away from flammables such as curtains, bedcovering, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or presents danger from electrical shock. D. Fireplaces and open flame heating shall not be utilized in sleeping rooms. E. Gas fired water heaters shall not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms. F. The facility shall be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means. G. All openings to the outside air used for ventilation shall be screened for the control of insects and rodents. Screen doors shall be equipped with self-closing devices. H. The facility shall have a system for maintaining the residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7.8.2.44 NMAC - Rp, 7.8.2.45 NMAC, 01/15/2010]	A 044		

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A 044	Continued From page 72 This REQUIREMENT is not met as evidenced by: 7.8.2.44 A Based on observation and interview the facility failed to ensure that the fuel-fired heating system and hot water heater were inspected, tested, and maintained annually by qualified personnel. This deficient practice has the potential for all 12 (R #s 1-12) residents identified on the census provided by the House Manager on 09/11/17, to be at risk of illness and harm if the furnace stops working during cold weather and/or has a gas/carbon monoxide leak and/or the hot water heater bursts due to corrosion and floods the facility. The findings are: Findings related to annual inspections: A. Record request for the annual inspection for the fuel fired heating system and the hot water heater, revealed that there was no documentation of any annual inspections having been conducted and available for review by the Licensing Authority. B. On 09/14/17 at 9:03 am, during interview with the House Manager, she confirmed that there was no documentation of any annual inspections of the hot water heater available for review and could not confirm if/when the last inspections occurred. Findings related to corrosion on water heater pipes: C. On 09/12/17 at 2:30 pm, during observation the hot water heater pipes were observed to have	A 044		

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A 044	Continued From page 73 corrosion on them. D. On 09/12/17 at 3:23 pm, during an interview with the Maintenance Director and Maintenance Assistant they confirmed that the hot water heater pipes were observed to have corrosion on them.	A 044		
A 045	7 NMAC 8.2.45 Water WATER: Pursuant to the current New Mexico drinking water requirements, 7.6.2.9 NMAC. A. The water supply system shall be constructed, protected, operated and maintained in conformance with applicable local, state and federal laws, ordinances and regulations. B. Where a facility is supplied by its own water system, the system shall meet the sampling and construction requirement of a non-community water system as defined by the current New Mexico drinking water requirements. C. All water that is not piped into the facility directly from a public water supply system shall be from an approved source, disinfected, transported, handled, stored and dispensed in a sanitary manner. Such water shall be prevented from entering potable water systems by appropriate cross connection and backflow prevention devices. D. Hot and cold running water, under pressure shall be provided in all areas where food is prepared and where equipment and utensils are washed, sinks, lavatories, washrooms and laundries. E. The hot water temperature that is accessible to residents shall be maintained at a minimum of ninety-five (95) degrees fahrenheit and a maximum of one hundred ten (110) degrees fahrenheit. Hot water in excess of one hundred ten (110) degrees fahrenheit is permitted in	A 045		

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kitchen and laundry areas, provided that residents are supervised in order to prevent injury.
[7.8.2.45 NMAC - Rp, 7.8.2.46 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.45 E

Based on observation and interview, the facility failed to ensure that the hot water temperatures were maintained within the range of 95 degrees Fahrenheit (F) and 110 degrees F. This deficient practice has the potential for all 12 (R #s 1-12) residents identified on the census provided by the House Manager on 09/11/17, to be at risk of injury from scalding hot water. The findings are:

A. On 09/13/17 at 10:34 am, during an observation, the water temperature in Resident Room (RR) #5 bathroom sink the hot water temperature was observed to be 129 degrees F.

B. On 09/13/17 at 10:36 am, during an observation, the hot water temperature in RR #1 shower was observed to be 120 degrees F.

C. On 09/13/17 at 10:38 am, during an observation, the hot water temperature in RR #4 bathroom sink was observed to be 130 degrees F.

D. On 09/13/17 at 10:41 am, during an observation, the hot water temperature in RR #2 shower was observed to be 120 degrees F.

E. On 09/13/17 at 10:43 am, during an observation, the hot water temperature in RR #3

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A 045	Continued From page 75 shower was observed to be 118 degrees F. F. On 09/13/17 at 10:45 am, during an interview with DCS #1, she confirmed the hot water temperatures in room #s 1-5 were above 110 degrees F.	A 045		
A 048	7 NMAC 8.2.48 Electrical System ELECTRICAL SYSTEM: A. All fuse and breaker boxes shall be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility shall know the location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances shall be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear. (2) Extension cords shall not be used. The use of a multi-socket united laboratories approved (U/L APPROVED) surge protector with integrated circuit breaker no greater than six (6) feet in length is permitted for the intended purpose and not as an extension cord. [7.8.2.48 NMAC - Rp, 7.8.2.49 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.48 GFCI NFPA 70 National Electric Code 210.8 Ground Fault Circuit Interrupter Protection for Personnel 210.8 (B) Other than dwelling units. All 125 volt,	A 048		

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A 048	Continued From page 76 single phase, 15 and 20 ampere receptacles installed in the locations specified in 210.8 (B)(1) through (8) shall have ground fault circuit interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception 1: to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow melting, de-icing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22 as applicable. Exception 2: to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2)shall be permitted for only those receptacles outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 6 ft. of the outside edge of the sink. Exception 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection	A 048		

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A 048	Continued From page 77 shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. 314.25: Covers and Canopies. In completed installations, each box shall have a cover, faceplate, lampholder, or luminaire canopy, except where the installation complies with 410.24(B) 406.5(F): Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. Based on observation and interview, the facility failed to ensure electrical outlets within 6 feet of a water source are fitted with Ground Fault Circuit Interrupter (GFCI) sockets. This deficient practice has the potential for all 12 (R #s 1-12) residents identified on the census, provided by the House Manager on 09/11/17, to be at risk of harm or death from electric shock or electrocution. The findings are: A. On 09/12/17 at 2:30 pm, during observation of the kitchen and laundry room with the Maintenance Director (MD) and Maintenance Assistant (MA) the following 9 electrical outlets within 6 feet of a sink (water source) were observed to not have GFCI sockets: 1. 7 outlets in the kitchen. 2. 2 outlets in the laundry room. B. On 09/12/17 at 3:23 pm, during interview with the MD and MA, they confirmed 9 electrical outlets within 6 feet of a water source did not have GFCI sockets.	A 048		

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A 049	7 NMAC 8.2.49 Doors DOORS: A. No door in any means of egress shall be locked against egress when the building is occupied. (1) Exit doors may be provided with a night latch, dead bolt, or security chain, provided these devices are operable from the inside, by any occupant, without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed forty-eight (48) inches above the finished floor. (2) If locks are not readily operable by all occupants within the building, the locks must: 1) unlock upon activation of the fire detection or sprinkler system and 2) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written approval from the building, fire and licensing authorities having jurisdiction. B. All exit doors shall have a minimum width of thirty-six (36) inches. (1) Facilities with a capacity of ten (10) or more residents shall have exit doors leading to the outside of the facility that open outward. (2) Facilities with a capacity of fifty (50) or more residents must provide panic hardware at the exit doors. (3) No door or path of travel to a means of egress shall be less than twenty-eight (28) inches wide. C. All resident sleeping room doors must be at least one and three-quarters (1 3/4) inch solid core construction. D. Bathroom doors may be twenty-four (24) inches wide. Facilities with four (4) or more residents shall have at least one bathroom for every eight (8) residents with a door clearance of thirty-six (36) inches for access by persons with disabilities.	A 049		

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	5870	A. BUILDING: ______ B. WING ______	C 09/14/2017

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A 049	Continued From page 79	A 049		

E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside.
F. All doors shall readily open from the inside.
G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms.
[7.8.2.49 NMAC - Rp, 7.8.2.50 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.49 A (1) (2), B (1), D (F)
Based on observation and interview, the facility failed to ensure that:
1. All exit door locks (deadbolt/night latch/turn knob) could be operated by any occupant of the facility or unlocked upon activation of the fire detection, sprinkler system, and/or during loss or power.
2. The night latch lock on the back exit door was mounted at the top of the door, was no higher that 48-inches from the floor, and could be operated by any occupant.
3. All resident room, and public bathroom doors can be readily opened from the inside.
4. All exit doors (facilities with 10 or more residents) leading to the outside open outward.

This deficient practice has the potential for all 12 (R #s 1-12) residents listed on the resident census, provided by the House Manager on 09/11/17, to be at risk of harm, injury, or death if a fire or other emergency requiring evacuation were to occur and if residents/staff and visitors are unable to exit the building because they were trapped behind locked doors that could not be opened by all occupants and did not automatically release upon activation of the fire detection, sprinkler system, and/or during loss or power.
The findings are:

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A 049	Continued From page 80 A. On 09/13/17 at 2:30 pm, during observation the following was observed: 1. The front door was observed to have a key deadbolt lock and a turn knob lock that when both were locked, did not unlock automatically upon activation of the fire detection, sprinkler system, and/or loss or power. 2. The back door was observed to have a key deadbolt lock, a turn knob lock, a night latch lock that when all 3 were locked did not unlock automatically upon activation of the fire detection, sprinkler system, and/or loss or power. 3. The 2 exit doors to the patio/back yard were observed to have both a deadbolt lock and turn knob lock that when locked, did not unlock upon activation of the fire detection, sprinkler system, and/or loss or power. 4. 7 of 10 resident room and 2 public bathroom doors were observed to have privacy locks (turn knob) that prevented the doors from being readily open from the inside. 5. 4 of 4 exit doors did not open outward. B. On 09/13/17 at 3:23 pm, during interview with the Maintenance Director and Maintenance Assistant they confirmed the above listed observations regarding the locks on the exit doors, resident room doors, and bathroom doors. The also confirmed that all 4 exit doors leading to the outside did not open outward.	A 049		
A 060	7 NMAC 8.2.60 Fire Clearence and Inspections FIRE CLEARANCE AND INSPECTIONS: A. Written documentation of a facility's compliance with applicable fire prevention codes shall be obtained from the state fire marshal ' s	A 060		

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A 060	Continued From page 81 office or the fire prevention authority with jurisdiction and shall be submitted to the licensing authority prior to the issuance of an initial license. B. The facility shall request an annual fire inspection from the local fire prevention authorities. If the policy of the local fire department does not provide an annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility. [7.8.2.60 NMAC - Rp, 7.8.2.59 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.60 B Based on record review and interview the facility failed to have any proof of an annual inspection from the fire authority having jurisdiction. This deficient practice has the potential for all 12 (R #s 1-12) residents listed on the census provided by the House Manager on 09/11/17 to be at risk of injury or death if there is a fire caused by an unsafe component of the building not being identified by inspection. The findings are: A. Record review of an annual fire inspection report from the local fire authority having jurisdiction dated 01/29/14, revealed that there had not been an annual fire inspection conducted since 01/29/14. B. On 09/13/17 at 4:29 pm, during interview with the House Manager, she confirmed that there had not been an inspection by the local fire	A 060		

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A 060	Continued From page 82 authority since 01/29/14.	A 060		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 B Reference NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition: 6.1.3 Placement. 6.1.3.1 Fire extinguishers shall be conspicuously located where they are readily accessible and immediately available in	A 063		

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A 063	Continued From page 83 the event of fire. 6.1.3.2 Fire extinguishers shall be located along normal paths of travel, including exits from areas. 7.2 Inspection. 7.2.1 Frequency. 7.2.1.1* Fire extinguishers shall be manually inspected when initially placed in service. 7.2.1.2* Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals.4-3 Inspection. Based on observation and interview, the facility failed to ensure that: 1. Portable fire extinguishers were maintained in accordance with NFPA 10 Standard for Portable Fire Extinguishers. 2. A fire extinguisher was located along all normal paths of travel and exits. This failed practice has the potential for all 12 (R #1-12) residents listed on the census, provided by the House Manager on 09/11/17 to be at risk of harm, injury, or death if the fire extinguishers do not operated correctly and/or are not available. The findings are: A. On 09/12/17 at 9:28 am, during observation of the 5 facility fire extinguishers it was revealed: 1. That the inspection tags for 4 of the fire extinguishers were not signed as inspected in May, June, or August 2017. 2. There was no fire extinguisher available on the West hallway near the exit. B. Record review of the Monthly Safety Reviews for May, June, and August 2017 revealed no	A 063		

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A 063	Continued From page 84 documentation that the fire extinguishers were inspected in May, June, or August 2017. C. On 09/12/17 at 9:35 am, during interview with the House Manager, she confirmed that the fire extinguishers were not being inspected each month.	A 063		
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 85 (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 86 (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 87 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 88 (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 89 This REQUIREMENT is not met as evidenced by: 7.8.2.68 B (1) C (2) D (2) (6) (a) Based on record review and interview the facility failed to ensure that: 1. Direct Care Staff (DCS) received an additional 6 hours of hospice specific training annually. 2. Individual Service Plan (ISP) reflects the coordination of care between the facility and the hospice provider. 3. A team meeting is held prior to accepting or retaining a hospice resident. This deficient practice has the potential for 2 (R #s 1 & 2) of 2 (R #s 1 & 2) residents receiving hospice services to be at risk of: 1. DCS not knowing the proper methods of providing hospice care and services. 2. DCS not knowing what services hospice provides and/or what services they are to provide for the resident. 3. Not receiving the highest level of care and services they need. The findings are: Findings for Hospice Training A. Record review of DCS #1's (date of hire: 06/18/17) staff file revealed, the 6 hours of training received were not dated or signed by a trainer and there is no documentation for one (1) hour specific to the hospice resident's ISP. B. On 09/13/17 at 10:45 am, during interview with the House Manger, she confirmed for DCS #1 that the six (6) hours of hospice specific training documentation is missing the date and	A 068		

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A 068	Continued From page 90 signature of the trainer and did not know when the training took place or by whom, and there is no documentation for one (1) hour specific training to the hospice resident's ISP. Findings for Team Meeting C. Record review of R #2's resident chart revealed no documentation that a team meeting was convened between the resident/Power of Attorney and the facility prior to admission to hospice services on 07/17/17. Findings for ISP D. Record review of R #1's resident chart revealed that an ISP was not developed to include hospice coordination of care and ISPs dated 03/05/15, 01/07/16, and 07/17/17 did not include hospice coordination of care for hospice services that began on 10/09/14. E. Record review of R #2's resident chart revealed that an ISP was not developed to include hospice coordination of care and the ISP 08/11/17 did not include hospice coordination of care for hospice services that began on 07/17/17. F. On 09/14/17 at 4:32 pm, during interview with the House Manger, she confirmed R #1 and R #2 did not have an ISP developed to include hospice coordination of care, ISPs in the files did not include hospice coordination of care when residents began receiving hospice services, and R #2 no documentation stating that a hospice team meeting was convened between the facility, resident/power of attorney and hospice agency.	A 068		

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A 069	Continued From page 91	A 069		
A 069	7 NMAC 8.2.69 Memory Care Units MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions: The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply. (1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer ' s gets progressively worse and is fatal. (2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services. (3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain. (4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program. (5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit. B. Care coordination requirement. An assisted living facility that accepts residents with memory	A 069		

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A 069	Continued From page 92 issues shall determine which additional services and care requirements are relevant to the resident and disease process. (1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services. (2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside health care provider. C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information. D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria: (1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs; (2) medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals:	A 069		

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A 069	Continued From page 93 (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. E. Assessments and reevaluations. (1) An assessment shall be completed by a registered nurse or a physician extender within fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5) days after admission. (a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission. (b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit. (c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted. (2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the	A 069		

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A 069	Continued From page 94 resident ' s stay in the assisted living facility memory care unit is still appropriate. F. Documentation in the resident ' s record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record: (1) the physician ' s diagnosis for admission to a secure environment or a memory care unit; (2) the pre-admission assessment; and (3) the re-evaluation(s). G. Secured environment. (1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to: (a) double alarm systems; (b) gates connected to the fire alarm; and (c) tab alarms for residents at risk for elopement. (2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents. (a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP;	A 069		

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A 069	Continued From page 95 (2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident ' s legal representative, if applicable and prior to the resident ' s admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for. (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.69 C F (1) Based on record review and interview the facility failed to ensure: 1. Direct Care Staff (DCS) received the required twelve (12) hours of annual training related to dementia. 2. There were physician's orders stating the	A 069		

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A 069	Continued From page 96 need for placement in a memory care unit. This deficient practice has the potential for all 12 (R #1-12) residents listed on the census, provided by the House Manager on 09/11/17 to be at risk of harm if: 1. Residents who do not require placement in a memory care (secured) unit to be inappropriately admitted against their will if their Primary Care Physician has not determined the placement is needed for personal safety due to Alzheimer's and other related dementia behaviors. 2. Residents do not receive the specialized care to meet the individual needs (physical, mental, social, etc) to maintain the highest level of quality of life because staff does not have the required training. Findings for Dementia Training: A. Record review of DCS #1's (date of hire: 06/18/17) staff file revealed, 12-hours of dementia training received were not dated or signed by a trainer. B. On 09/13/17 at 10:45 am, during interview with the House Manager, she confirmed DCS #1's 12-hours of dementia training was not dated or signed by a trainer and did not know when the training took place or by whom. Findings for Dr Orders: C. Record review of the physician orders for R#'s 1-4 revealed there were no physician orders stating the need for residents to be placed in a memory care (secured) unit. D. On 09/13/17 at 3:20 am, during interview with	A 069		

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A 069	Continued From page 97 the House Manager, she confirmed R #1-4 did not obtain physician orders stating the need for residents to be placed in a memory care (secured) unit.	A 069		
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 F 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2)	A 070		

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A 070	Continued From page 98 W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. 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. That an internal	A 070		

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A 070	Continued From page 99	A 070		

investigation was conducted and a follow-up report was submitted within 5 business days to the Licensing Authority. This deficient practice has the potential for all 12 (R #s 1-12) listed on the resident census provided by the House Manager on 09/11/17 to be at risk of being abused, neglected, and/or not receiving needed medical care and services if incidents are not being reported as required. If the facility is not conducting internal investigations and submitting their findings to the Licensing Authority, then residents are at risk of continued suffering and further injury if there is no oversite of the care and services the facility is providing. The findings are:

Findings related to Incident Reports

A. Record review of the internal Incident Reports for R #1, revealed there was no documentation that the following incidents were reported to the Licensing Authority:
1. On 04/07/16, R #1 had an unwitnessed fall (staff did not actually see the fall, but heard a load cry) with injury (2 skin tears to arm).
2. On 05/26/16, R #1 had an unwitnessed fall with injury to her nose (rug burn/scrape).
3. On 06/07/16, R #1 had an unwitnessed fall with injury to her nose (scrape).

B. Record review of the internal Incident Report dated 10/30/16 for R #4, revealed there was no documentation that an incident of aggressive behavior (resident to resident abuse), resulting in the paramedics and police being called was reported to the Licensing Authority.

C. Record review of the internal Incident Report dated 03/21/16 for R #6, revealed there was no documentation that an incident of an unwitnessed fall with injury (scrape on back) and anxiety

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A 070	Continued From page 100 requiring medication was reported to the Licensing Authority. D. Record review of the internal Incident Reports for R #9, revealed there was no documentation that the following incidents were reported to the Licensing Authority: 1. On 07/11/16, R #9 was found on the floor, unable to get up on her own, with a small bruise on her left side under her ribs. 2. On 09/24/16, R #9 was found with blood on her sheets/pillows and her wrist was swollen, red with an open wound/scratch on it. E. Record review of the Internal Incident Reports for R #10 revealed there was no documentation that the following incidents were reported to the Licensing Authority: 1. On 12/18/16, R #10 had an incident of resident to staff abuse/aggressive behavior, when Direct Care Staff (DCS) #5 tried to redirect him out of another resident's room. R #10 put his arms around her [DCS] waist, gripped her wrists firmly, she feared he was going to throw her down, before DCS #2 was able to distract him. He calmed down after he took his medications. 2. On 12/22/16, R #10 had an unwitnessed fall with injury (carpet burn on arm). He was in his room alone after becoming upset when staff tried to assist him with taking off his pants. F. On 09/14/17 at 9:37 pm, during interview with the House Manager she confirmed that the reportable incidents for R #s 1, 4, 6, 9 and 10 were not reported to the Licensing Authority. Findings related to 5-day follow-up report G. Record review of the 5-day follow up report dated 10/31/16 (24-days late), for the self-report	A 070		

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A 070	Continued From page 101 dated 09/19/16, for R #1, revealed that the 5-day follow-up report was not submitted to the Licensing Authority until after receiving notice of non-compliance during the survey on 10/19/16. H. On 09/14/17 at 2:05 pm, during interview with the House Manager, she confirmed that the follow-up report for R #1 was not submitted to the Licensing Authority within 5 business days after the incident and was 24-days late.	A 070		