STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4032	A. BUILDING: _____ B. WING _____	C 03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY AT SANTA FE	3 AVENIDA ALDEA SANTA FE, NM 87507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Full-Onsite/Complaint survey completed on 03/05/20 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint #NM41541 was substantiated with deficiencies cited. Complaint #NM42872 was substantiated with deficiencies cited. Complaint #NM42334 was substantiated with deficiencies cited.	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;	A 017		

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A 017	Continued From page 1 (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 C (1-10,12) This is a repeat deficiency from survey dated 10/30/20. Based on record review and interview the facility failed to ensure that the Direct Care Staff (DCS) received the all of the required annual trainings. This deficient practice could likely result in harm or injury for all 32 (R #s 1-32) residents identified on the census provided by the Administrator on 03/04/20, if the DCS have not received all required annual trainings and do not know how to properly care for residents. The findings are: A. Record review of DCS #3's employee file (date of hire 07/16/18) revealed no documentation of receiving the following annual trainings:	A 017		

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A 017	Continued From page 2 (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; 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) methods to provide quality resident care; (9) emergency procedures; (10) the proper way to implement a resident ISP for staff that assist with ISPs. B. Record review of DCS #4's employee file (date of hire 11/07/17) revealed no documentation of receiving the following annual trainings: (1) first aid (2) the proper way to implement a resident ISP for staff that assist with ISPs. C. Record review of DCS #5's employee file (date of hire 04/24/18) revealed no documentation of receiving the following annual trainings: (1) 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; and (e) infectious and communicable disease control;	A 017		

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A 017	Continued From page 3 D. On 03/29/19 at 4:12 pm, during an interview, the Business Office Manager confirmed that DCS #s 3-5 had not received/completed the required annual trainings,	A 017		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the	A 020		

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A 020	Continued From page 4 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 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;	A 020		

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A 020	Continued From page 5 (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 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 020		

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A 020	Continued From page 6 (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 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]	A 020		

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A 020	Continued From page 7 This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) Refer to Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings. B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and	A 020		

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A 020	Continued From page 8 storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of thm. C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health." SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately. Based on record review and interview the facility failed to ensure for 2 (R #s 1-2) of 2 (R #s 1-2) residents whose Admission/Discharge Agreements were reviewed for compliance included a refund policy for death policy that was in compliance with NMAC 7.8.2.20 and Senate Bill (SB) 0335 - 2013. This deficient practices could likely cause the resident's estate/legal representative to be at risk of financial hardship if they are not aware of the monies to be refunded or the possible storage costs that may occur. The findings are: A. Record review of R #s 1-2 Admission/Discharge agreements revealed they did not include the refund policy for death as specified in SB 0335 - 2013. B. On 03/04/20 at 2:32 pm, during an interview, the Executive Director confirmed that the required SB0335-2013 information was missing from R #s	A 020		

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A 020	Continued From page 9 1-2 Admission/Discharge Agreements. .	A 020		
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and 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	A 022		

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A 022	Continued From page 10	A 022		

facility and the fire safety evaluation system (FSES) rating, if applicable;
(10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of 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

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A 022	Continued From page 11 the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (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	A 022		

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A 022	Continued From page 12 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (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]	A 022		

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A 022	Continued From page 13 This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (10) (a-b) Based on record request and interview, the facility failed to ensure that there were written emergency evacuation plans for both facility only and community wide disasters. This deficient practice has the potential for all 32 (R #s 1-32) residents listed on the census provided by the Administrator on 03/04/20 to be at risk of harm, injury, illness and/or death if a facility only or community wide disaster occurred and the residents were unable to be safely evacuated from the facility or community. The findings are: A. Record request for the emergency evacuation plan for facility only disasters revealed no documentation that the facility had a plan in place. B. Record request for the emergency evacuation plan for community wide disasters revealed no documentation that the facility had a plan in place. C. On 03/04/20 at 3:30 pm, during an interview with the Maintenance Director, he confirmed that the facility did not have emergency evacuation plans for both facility only and community wide disasters.	A 022		
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,	A 032		

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A 032	Continued From page 14 neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) B 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS	A 032		

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A 032	Continued From page 15 Refer to 7.1.13.7 W & 8 B (2) W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor ' s order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division ' s incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau ' s incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure for 2 (R #s 6 and 7) of 5 (R #s 1-2, 6-8) residents whose resident files were reviewed for compliance, that incidents of unusual occurrence which has or could likely threaten the health, safety, or welfare of the residents: 1. Were reported to the Licensing Authority	A 032		

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within 24 hours or the next business day if a holiday or weekend.

2. That a follow-up investigation report was submitted to the Licensing Authority within 5 business days from the date of the incident.

This deficient practice could likely result in all residents to be at risk of harm, injury, and/or death, if there is no oversight by the Licensing Authority. The findings are:

Findings related to R #6

A. Record Review of an email dated 02/21/20 from the Executive Director to the Corporate Office concerning an internal investigation of (2) two incidents that occurred on 02/12/20 involving R #6, revealed that:

1. On 02/12/20 R #6 reported that (13) [redacted]

2. On 02/12/20 Direct Care Staff (DCS) #7 reported to the facility that while R #6 was out of the facility, she and DCS #16 were in the residents room and she observed DCS #16 pocketing [redacted]

3. The Executive Director reviewed video footage outside of R #6s room and saw DCS #16 entering the residents room alone approximately (1) one hour later, while the resident was still out of the facility.

4. The Executive Director stated that DCS #16 was implicated, placed on Administrative leave, and suggested she should be terminated.

B. Record review of the facility's 2020 Internal Incident Reports file and R #6s resident files revealed no documentation that the facility submitted a:

1. Self-report regarding the incident to the

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A 032	Continued From page 17 Licensing Authority within 24 hours or the next business day if a holiday or weekend. 2. Follow-up report to the Licensing Authority within 5 business days after the 02/12/20 incident occurred. Related to R #7 C. Record Review of the facility's 2020 Internal Incident Reports file revealed that on 01/05/20 R #7 was [redacted] D. Record Review of the facility's Incident Reports filed with the Licensing Authority revealed no documentation the facility submitted a Self-Report to the Licensing Authority with in 24 hours of the next business day if a holiday or weekend. E. Record Review of the facility's Incident Reports filed with the Licensing Authority revealed no documentation that a investigation follow-up report was submitted to the Licensing Authority within 5 business days after the incident. F. On 03/04/20 at 1:32 pm, during an interview with the Executive Director, she confirmed that the incidents for R #s 6 & 7 that facility did not submit a: 1. Self-Report to the Licensing Authority within 24 hours or the next business day if holiday or weekend. 1. 5-day investigation follow-up report to the Licensing Authority within 5 business days from the incident.	A 032		

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A 033	Continued From page 18	A 033		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a 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	A 033		

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services provided by the facility and their costs and give advance written notice of any changes;
(4) provide residents with a safe and sanitary living environment;
(5) provide humane care for all residents;
(6) provide the right to privacy, including privacy during medical examinations, consultations and treatment;
(7) protect the confidentiality of the resident ' s medical record;
(8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room;
(9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations;
(10) prohibit the use of any and all physical and chemical restraints;
(11) ensure that residents:
(a) are free from physical and emotional abuse neglect and misappropriation/or exploitation;
(b) are free from financial abuse and misappropriation by facility staff or management;
(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

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A 033	Continued From page 20 informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (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]	A 033		

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A 033	Continued From page 21 This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (11) (a) " Neglect " means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness and is defined in the Incident Reporting Intake, Processing & Training Requirements, 7.1.13 NMAC. Based on record review and interview the facility failed to ensure the safety and welfare of 1 (R #5) of 1 (R #5) resident who required medical attention after leaving the facility with a friend (Visitor #1) for 3 days without his medications and the facility neglected to inform his legal representatives until after his return. This deficient practice could likely result in risk of harm, injury, and/or death if the resident is taken from the facility without medication. The findings are: A. Record review of a psychological evaluation dated 10/18/18 revealed, that R #5 was found to have significant functional decline, no capacity to make decisions regarding medical/financial matters, and a recommendation of 24 hour supervision B. Record review of emails dated 05/14/19, 05/06/19, and 11/04/19 reveled that both the financial and medical Power of Attorneys (POAs) expressed concern and requested that with R #5 not be allowed visits with Visitor #1. C. Record review of R #5's progress notes revealed that: 1. On 12/19/19 at 4:08 pm, the Executive Director (ED) noted that R #5 had checked out of	A 033		

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A 033	Continued From page 22 the facility on 12/18/19 with Visitor #1 and had not returned. ED called Visitor #1 to inform her that R #5 had been without [redacted] medications. 2. There was no documentation that either R 5's Medical or Financial POAs were contacted regarding the resident having left the facility with Visitor #1 without [redacted] medications, until after [redacted] return on 12/20/20 and in need of medical treatment/services. 3. On 12/20/19 at 2:04 pm, the ED noted that R #5's medical POA was contacted due to resident complaining of [redacted] and that the medical POA would be coming to take [redacted] to the Urgent Care. D. Record review of the visitor log reveled that R #5 had no visitors between 12/18/19 and 12/19/19. E. On 03/18/20 at 11:01 am, during an interview, the Executive Director stated that she did notify R #5's medical POA of the resident's absence on 12/19/19. However, she confirmed that there was no documentation in the resident's chart of the notification. F. On 03/18/20 at 11:10 am, during an interview, the Financial POA, stated that there was no notification to him or the Medical POA of R #5's absence from the facility with Visitor #1 until 12/20/19 after the resident was returned to the facility and in need of medical treatment/services.	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 this rule and that assists with self-administration or safeguards medications for residents shall	A 034		

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A 034	Continued From page 23 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 for the administration of inhalation therapy and for resuscitative purposes shall comply with the	A 034		

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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 administrator within seventy-two (72) hours.
(2) A system of records of receipt and disposition

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A 034	Continued From page 25 of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (1) (4-5) (9) This is a repeat deficiency from survey dated 10/30/19. Based on observation, record review, and interview the facility failed to ensure for 2 (R #s 1 & 2) of 4 (R #s 1-4) residents sampled for compliance that: 1. Prescribed medications were readily available at the facility. 2. Prescribed medications were labeled in compliance with state regulations. 3. There was a physician's order to self administer medications. 4. There was a physician's order to keep over the counter and prescribed medications stored in a locked compartment in the resident's room. 5. Discontinued medications were inventoried, moved to a separate locked storage container, and destroyed upon the next quarterly	A 034		

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visit by the consulting pharmacist.

These deficient practices could likely result in all residents to be at risk of illness, injuries, and/or death if:

1. Resident physician ordered medications were not available at the facility.
2. Prescribed medications are not labeled in compliance with state regulations.
3. Resident's are self-administering their own medications without a physician's order and the facility's knowledge.
4. Medications kept in the resident's rooms are not stored in a locked compartment or accessible to other residents.
5. Residents take the wrong medications because discontinued medications were not removed from the medication cart.

The findings are:

Findings for R #1

A. Record review of the R #1's [redacted] 2020 Medication Administration Records (MAR) revealed, the following medication doses were missed because the medications were not available at the facility.

[redacted]

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[redacted]

B. On 03/05/20 at 2:00 pm during observation of the Medication cart the following medications were observed in the cart but were not listed on R #1's [redacted] 2020 MAR:

[redacted]

Record review or R #2

C. Record review of the R #2's [redacted] 2020 MAR revealed, the following doses of medications were missed due to being on back order and not available at the facility.

[redacted]

D. On 03/05/20 at 2:00 pm during observation of the Medication cart [redacted]

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A 034	Continued From page 28 [redacted] E. Record review of R #2s [redacted] 2020 MAR revealed that [redacted] F. On [redacted]/20 at 2:00 pm, durning observation of R #2s medication on the facility med cart revealed the following: [redacted] G. On 03/05/20 at 4:33 pm, during an interview with the Administrator, she confirmed the findings listed above for R #s 1 and 2 medications.	A 034		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals.	A 035		

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A 035	Continued From page 29 B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident.	A 035		

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A 035	Continued From page 30 G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication;	A 035		

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A 035	Continued From page 31 (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled	A 035		

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A 035	Continued From page 32 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 H K (1) (3) (5) M Repeat Deficiency from 10/30/19 Full On-site Survey. Based on record review and observation the facility failed to ensure for 2 (R #s 1 and 2) of 4 (R #s 1-4) residents whose Medication Administration Records (MARs) were reviewed for compliance were complete, accurate and includes all required information. This deficient practice could likely result in medication errors that negatively affect on the health, safety and welfare of all residents if the information on the MAR is not accurate, complete, included all required information and medication errors. The findings are: A. On 03/05/20 at 2:00 pm, during observation of R #1s medication container for [redacted] it was observed to not: 1. Be in a prescription bottle (sample). 2. Have a pharmacy label. 3. Have R #1s name 4. Have the date the prescription was issued. 5. Have the name of the prescriber B. Record review of R #2s 03/01/20 thru	A 035		

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A 035	Continued From page 33 [redacted]/20 MAR revealed [redacted] C. On 03/05/20 4:33 pm during an interview, with the Executive Director, she confirmed the medication findings listed above for R #s 1 & 2.	A 035		
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 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	A 038		

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A 038	Continued From page 34 by: 7.8.2.38 C Based on observation and interview, the facility failed to ensure that poisonous cleaning supplies were not stored in food areas and accessible to residents. This deficient practice could likely result in all 32 (R #s 1-32) residents identified on the census provided by the Administrator on 03/04/20, to be at risk of harm, illness, or death if residents were to ingest or spill the poisonous cleaning supplies on themselves. The findings are: A. On 03/04/20 at 11:45 am, during observation of the kitchen the following poisonous cleaning supplies were observed to be stored unsecured/unlocked cabinet under the snack bar sink and accessible to residents: 1. (1) 19 oz disinfectant spray 2. (3) 32 oz disinfectant spray 3. (1) 19 oz glass cleaner B. On 03/04/20 at 2:10 pm, during an interview with the Maintenance Director, he confirmed that the above listed poisonous cleaning supplies were stored in an unsecured/unlocked cabinet under the snack bar sink and accessible to residents.	A 038		
A 054	7 NMAC 8.2.54 Resident Rooms RESIDENT ROOMS: A. The facility ' s bed capacity shall not exceed the capacity approved by the licensing authority. B. Each resident room shall have an outside room with a window. The area of the outdoor window shall be at least one tenth (1/10th) of the floor area of the room.	A 054		

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A 054	Continued From page 35 C. Resident rooms shall not be less than seven (7) feet wide in any horizontal dimension. D. There must be no through traffic in resident rooms. Resident rooms must connect directly to other internal common areas of the facility. E. The window shades, drapes, curtains, or blinds in the resident rooms shall be in good repair and of flame-retardant materials. F. Resident rooms may be private or semi-private. Semi-private rooms may not house more than two (2) residents. (1) Private rooms shall have a minimum of one hundred (100) square feet of floor area. The closet and locker area shall not be counted as part of the available floor space. (2) Semi-private rooms shall have a minimum of eighty (80) square feet of floor area for each bed and shall be furnished in such a manner that the room is not crowded and passage out of the room is not obstructed. A separate closet for each resident shall be provided. The closet and locker area shall not be counted as part of the available floor space. The beds shall be spaced at least three (3) feet apart. G. If a resident chooses not to bring their own furnishings to the facility; each resident room shall be provided with, as a minimum, the following furnishings per resident: (1) a bed that shall be at least thirty-six (36) inches wide, of sturdy construction and in good repair; (2) each bed shall be provided with a clean, comfortable mattress of at least four (4) inches in thickness, which is waterproof, or protected with a waterproof covering and a mattress pad; (3) each bed shall be provided with a clean, comfortable pillow; (4) each bed shall be provided with a pillow case, two (2) clean sheets, blankets and a bedspread	A 054		

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A 054	Continued From page 36 appropriate for the weather and the climate; (5) an individual closet or closet area with a clothes rack for hanging clothes and shelves or drawers that are accessible to the resident; (6) a dresser with drawers; (7) a bedside table or desk; (8) a chair; (9) a reading lamp; and (10) a mirror. [7.8.2.54 NMAC - Rp, 7.8.2.55 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.54 G (1-10) Based on record review and interview the facility failed to ensure that the residents have the option of having a furnished room with all items required by regulation. This deficient practice could likely result in the 32 (R #s 1-32) residents listed on the census, provided by the Administrator on 03/04/20, to not be provided with the minimum furniture as required by regulation, which may then cause a resident to have to sleep on the floor. The findings are: A. Record review of R #s 1 & 2 Resident Admission Agreements revealed that in incorrectly stated that the resident "shall furnish the suite with all necessary furniture." B. On 03/04/20 at 2:32 pm, during an interview, the Executive Director confirmed that the residents are required to provide all of the furniture for their suites.	A 054		

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A 069	Continued From page 37	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 38 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 39 (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 40 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 41 (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 Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS) received twelve (12) hours of Dementia/Alzheimer's training annually. This deficient practice could likely result in the 5 (R #s 1-5) residents diagnosed with dementia (memory	A 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4032	A. BUILDING: _____ B. WING _____	C 03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 069	Continued From page 42 loss) as identified on resident list provided by Administrator on 03/04/20, to be at risk of not receiving the individual (physical, mental, social) care and services needed if the DCS have not completed the required trainings. The finding are. A. Record review of DCS #3's employee file (date of hire 07/16/18) revealed no documentation of receiving the required twelve (12) hours of annual dementia/Alzheimer's training within the past year. B. Record review of DCS #4's employee file (date of hire 11/07/17) revealed documentation of only receiving .25 hours of the required twelve (12) hours of annual dementia/Alzheimer's training within the past year. C. Record review of DCS #5's employee file (date of hire 04/28/18) revealed documentation of only receiving two (2) hours of the required twelve (12) hours of annual dementia/Alzheimer's training within the past year. D. On 03/05/20 at 4:12 pm, during an interview, the Business Office Manager confirmed that DCS #s 3-5 had not received/completed the required twelve (12) hours of annual dementia/Alzheimer's training.	A 069		