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	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUROS DE SALVACION	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

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A 000	Initial Comments The following deficiencies are the result of a complaint survey completed on 01/05/11 for the requirements of NMAC 7.8.2, regulations governing New Mexico for Assisted Living Facilities. Complaint #'s 27799 and 27818 were investigated and found to be substantiated for NMAC 7.8.2.21. Deficiencies were 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; (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 (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: Refer to 7.8.2.17 STAFF TRAINING (A. through C.) Based on record review and interview the facility failed to provide any orientation or any training to 7 of 7 staff members(#9 through #15). This deficient practice had the potential to present a risk of harm to the health and safety of the facility residents. The findings are: A. Review of staff records revealed no orientation, trainings or medication assistance certificates for Staff Members #9 through #15. B. On 02/08/11 at 9:39 am, a telephone interview was conducted with Staff Member #9. Staff Member #9 acknowledged she did not receive any training from the facility. C. On 02/09/11 at 9:34 am, a telephone interview was conducted with Staff Member #13. Staff Member #13 acknowledged that she had "worked at the facility from approximately the third week in October, 2010 to mid November, 2010." Staff	A 017		

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A 017	Continued From page 2 Member #13 acknowledged she had been working at the facility for about 3 weeks , and stated that she had never been offered any training from the facility. D. On 02/08/11 at 3:27 pm, a telephone interview was with former Staff Member #14. Staff Member #14 acknowledged the facility had not provided her with any training. E. On 12/14/10 at 1:45 pm, an interview was conducted with the owner of the facility. The owner was given a list of documents needed for record review, which included a request for all staff training records. On 01/05/11, at the time of the exit conference, training records had still not been provided by the facility.	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;	A 020		

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A 020	Continued From page 3 (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 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	A 020		

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A 020	Continued From page 4 (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 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	A 020		

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A 020	Continued From page 5	A 020		

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 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

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A 020	Continued From page 6 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: Refer to 7.8.2.20 C. Exceptions to admission, readmission and retention. Based on record review and interview, the facility failed to have evidence of a team meeting to determine if residents needs could be met at the facility for 2 (#1 and #2) of 2 (#1 and #2) residents receiving services that were provided by an outside health care provider. This deficient practice had the potential to cause duplication of a services and/or lack of needed services for the residents. The findings are: A. Review of records for Resident #1 and #2 revealed both were receiving services from a Home Health Agency. There was no documentation of a team meeting to determine if the residents needs could be met at the facility. B. On 12/15/10 at 11:45 am, an interview was conducted with the owner of the facility. The owner acknowledged there was no team meetings to determine if the residents needs could be met at the facility for Residents #1 and #2.	A 020		

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A 020	Continued From page 7 Refer to 7.8.2.20 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. Based on record review and interview, the facility failed to have evidence of care coordination on the Individual Service Plan (ISP) for services that were provided by an outside health care provider for 2 (#1 and #2) of 2 (#1 and #2) residents. This deficient practice had the potential to cause duplication of a services and/or lack of needed services for 2 residents. The findings are: A. Review of records for Resident #1 and #2 revealed both were receiving services from a Home Health Agency. Review of the ISPs for Residents #1 and #2 revealed no documentation of the Home Health services being provided by the Home Health providers. B. On 12/15/10 at 11:45 am, an interview was conducted with the owner of the facility. The owner acknowledged there was no documentation of Coordination of Care for Residents #1 and #2.	A 020		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person	A 021		

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A 021	Continued From page 8 making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment	A 021		

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A 021	Continued From page 9 or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident,	A 021		

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A 021	Continued From page 10 documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.21 A. Each resident record shall include: (2) The resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; Based on record review and interview, the facility failed to have an evaluation completed for 1 (#1) of 2 residents charts reviewed that were currently residing in the facility (#1). This has the potential for improper and lack of care of a resident. The findings are:	A 021		

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A 021	Continued From page 11 A. Review of records for Resident #1 revealed no evaluation documentation. Resident #1 was admitted to the facility on [redacted]10. B. In an interview with owner on 12/15/10 at 11:45 am, the owner acknowledged there was no evaluation done on Resident #1. Refer to 7.8.2.21 A. Each resident record shall include: (4) the physical examination report . . . within ten (10) days of admission; . . . Based on record review and interview, the facility failed to have a physical examination report for 1 of 2 resident that had resided at the facility for more than 10 days (#1). The findings are: A. Review of records for Resident #1 revealed no physical examination report from a primary care physician, a nurse practitioner or a physician's assistant. Records obtained from the Home Health agency providing services for Resident #1 revealed Resident #1was admitted to the assisted living facility on [redacted]10. B. During an interview with owner on 12/14/10 at 8:45 am, the owner was asked for the physical examination report (history and physical) for Resident #1. The Owner acknowledged the facility did not have the report.	A 021		
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and	A 022		

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A 022	Continued From page 12 procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained; (7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction; (8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks; (9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSES) rating, if applicable; (10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of	A 022		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

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A 022	Continued From page 14 (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas; (7) accommodation of resident ' s pets; and (8) resident use of electric blankets and appliances. D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas: (1) actions to be taken in case of accidents or emergencies; (2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission; (3) policy for medication errors; (4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.); (5) the handling of resident's funds, if the facility provides such services; (6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy;	A 022		

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A 022	Continued From page 15 (12) admission agreement; (13) admission records; (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.22 A. Reports and Records. Each facility shall keep the following reports, records, policies and procedures on file at the facility . . . (11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC.	A 022		

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	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

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A 022	Continued From page 16 Based on record review and interview the facility failed to have a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC. This deficient practice can affect all staff, residents, and visitors at the facility. The findings are: A) During review of records at the facility, no copy of this rule, "Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC" was observed in the records. B) In an interview with owner staff #16 on 12/15/10 at 11:45 am, owner staff #16 was asked for a copy of this rule; Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC. At the time of exit on 1/5/10 at 1:45 pm, this document had not been provided to this surveyor.	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:	A 026		

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A 026	Continued From page 17 (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.26 B. The ISP shall include the following: (1 through 10). Based on record review and interview the facility failed to have an Individual Service Plan (ISP) that addressed the needs for 1 of 2 resident charts reviewed (#1). This deficient practice had the potential to cause inappropriate and/or lack of care for a resident. The findings are: A) Review of the ISP for resident #1 revealed no evaluation or history and physical on file at the facility to provide information to formulate an ISP to address the needs of resident #1. B) Review of the records obtained from the	A 026		

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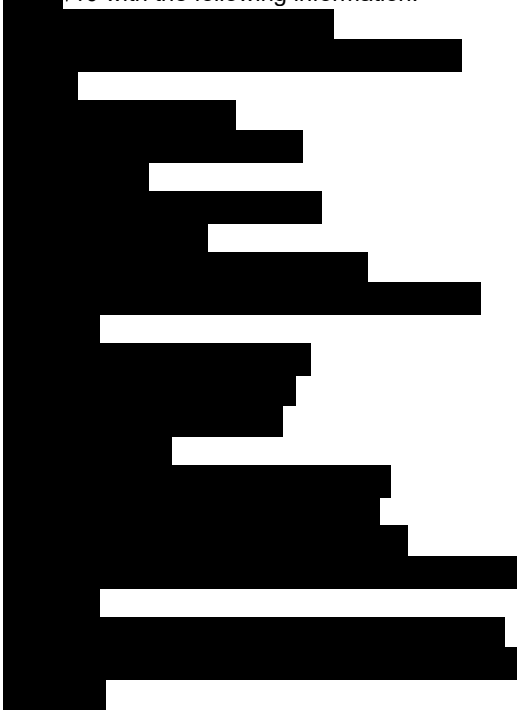
A 026	Continued From page 18 Home Health Agency that provides services for resident #1, revealed an assessment dated [redacted]/10 with the following information:  C) In an interview with owner on 12/15/10 at 11:45 am, the owner was asked why the ISP did not address all of the required needs for resident #1. The owner responded, "Paper work is only needed for you."	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	A 032		

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A 032	Continued From page 19 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: Refer to 7.8.2.32 REPORTING OF INCIDENTS and 7.1.13.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR LICENSED HEALTH CARE FACILITIES: A. Duty To Report: (1) All licensed health care facilities shall	A 032		

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A 032	Continued From page 20	A 032		

immediately report abuse, neglect or misappropriation of property to the adult protective services division.
(2) All licensed health care facilities shall report abuse, neglect, misappropriation of property, and injuries of unknown sources to the division within a twenty-four (24) hour period.
(3) All licensed health care facilities shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.
B. Notification:
(1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident either independently or through the licensed health care facility to the division by telephone call, written correspondence or other forms of communication utilizing the division ' s incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number (1 800 752 8649).
(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 all incident report forms alleging abuse, neglect or misappropriation of consumer property submitted by a reporter with direct knowledge of an incident are completed on the division ' 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

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A 032	Continued From page 21 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 prepares the incident report form. C. Incident Policies: All licensed health care facilities shall maintain policies and procedures which describes the licensed health care facility ' s immediate response to all reported allegations of incidents involving abuse, neglect, misappropriation of consumer property, injuries of unknown sources, and deaths, as applicable. D. Retaliation: Any individual who, without false intent, reports an incident or makes an allegation of abuse, neglect or exploitation will be free of any form of retaliation. F. Quality Improvement System for Licensed Health Care Facilities: The licensed health care facility shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. [7.1.13.8 NMAC - N, 02/28/06] This requirement is not met as evidenced by: Refers to 7.8.2.32 REPORTING OF INCIDENTS and 7.1.13.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR LICENSED HEALTH CARE FACILITIES: (listed above) Based on record review and interview the facility failed to ensure the following: 1. report an injury of unknown source to the Health Facilities Licensing and Certification	A 032		

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A 032	Continued From page 22	A 032		

(HFL&C),
2. report to HFL&C within 24 hours,
3. have the injury reported by the person with direct knowledge of the incident,
4. conduct an investigation of the incident for 1 of 2 resident charts reviewed (#1),
5. have incident policies, and
6. have a Quality Improvement System for Licensed Health Care Facilities.
This deficient practice had the potential to affect the health and safety of the residents at the facility. The findings are:

A) Review of records for resident #1 revealed the following "Progress Note" from staff #9 dated 11/19/10: "[resident #1] I came in and [redacted] had a [redacted] on [redacted] I don't know what happened, but [resident #1] said [staff #15] was mean to [redacted] and was saying [redacted] stuff to [redacted] called and [resident #1] told her the same thing. [Home Health Nurse] came to see [redacted] and [redacted] also told her." There was no documentation of the incident from staff #15 at the facility. Records revealed staff #15 was the only staff at the facility when the incident occurred.

B) Review of records obtained from the Home Health Agency providing nursing services for resident #1 revealed the Home Health "Nurse's Visit Slip dated 11/19/10 which documented the following: "Patient [resident #1] unclear how [redacted] this morning. Just states [redacted] will never allow what happened to happen again. . . . No entry in narrative [facilities] log on patient concerning [redacted] Day attendant states she was told patient had just [redacted] prior to her arrival and she was asked to dress wound. Dry blood found on bed sheets near exit side of bed. Found [redacted] with [redacted]

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A 032	Continued From page 23 [redacted] C) In an interview with owner on 12/14/10 at 1:45 pm, this surveyor asked owner for all incident reports, incident policies, and quality improvement system for reviewing alleged complaints and incidents. Owner said, "No incidents." At the time of exit on 01/05/11 none of these documents had been provided. D) On 12/16/10 at 3:00 pm, this surveyor called the phone numbers listed for resident #1's spouse and one number was disconnected and the other had no service.	A 032		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident;	A 033		

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A 033	Continued From page 24 (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; (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 033		

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A 033	Continued From page 25 (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 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	A 033		

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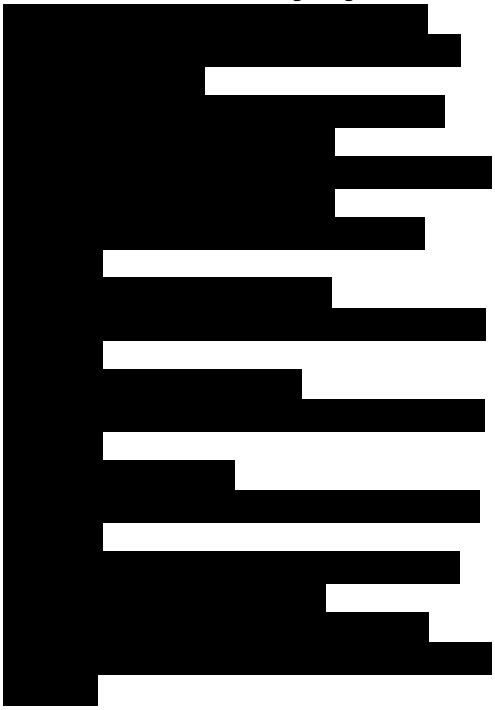
A 033	Continued From page 26 recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the 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: Refer to 7.8.2.33 D. (11) ensure that resident: (a) are free from . . . neglect . . . Also refer to 7.8.2.7 AW. "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness and is defined in the Incident Reporting Intake, Processing & Training Requirements, 7.1.13 NMAC. Based on record review and interview, the facility failed to provide services for 1 of 2 residents (#1). This failed practice had the potential to cause physical harm and mental anguish for resident #1. The findings are: A) Review of records at the facility for resident #1 revealed an Individual Service Plan that did not address his needs, a Customer Medication Profile, and Medication Administration Record only. There were no admission agreement, resident evaluation form, physical examination report (no diagnoses or history), coordinated care plan, documentation of an admissions/retention	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUROS DE SALVACION	**10405 THERESA PLACE NE ALBUQUERQUE, NM 87111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 27 team meeting, demographic information, or information of the home health services provided by the Home Healthcare agency. The ISP only read, "ADL max assist [with] to bathe, dress, encourage activity." The "Customer Medication Profile had a "Home Healthcare agency letterhead, but no handwritten or electronic signature. It listed the medications for resident #1, which included Oxygen 4 Liters Continuous. B) Review of records obtained by this surveyor from the Home Healthcare agency. The Home Healthcare records revealed a Home Health Certification and Plan of Care for Resident #1 electronically signed by a Physician on 09/30/10 which revealed the following diagnoses: 	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUROS DE SALVACION	**10405 THERESA PLACE NE ALBUQUERQUE, NM 87111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 28 C) Review of records obtained by this surveyor from the Home Healthcare agency revealed a Home Health Certification and Plan of Care for Resident #1 electronically signed by a Physician on 11/05/10 which revealed the following: [redacted]	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUROS DE SALVACION	**10405 THERESA PLACE NE ALBUQUERQUE, NM 87111**

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A 033	Continued From page 29	A 033		

[redacted]

D) Review of records obtained by this surveyor from the Home Home Healthcare agency for resident #1 revealed several visit slips where the following information was documented:
1. Resident #1 was admitted to (assisted living) on [redacted]/10.
Visit Slip from the Home Health nurse, (Sn) dated [redacted]/10 documented that when she arrived at the assisted living facility, Resident #1 was not wearing [redacted] it was connected to was empty [redacted] and [redacted] color was dusky. Resident #1 [redacted] around the facility without stand by assistant and is a [redacted] due to getting [redacted] Also noted Resident #1 was abruptly placed in an Assisted Living Facility with no care plan and did not receive [redacted] morning medications.
2. Visit slip dated 10/27/10 from the Home Healthcare (HH) nurse documented the facility still had no individual service plan or care plan for resident #1.
3. Visit Slip dated 11/15/10 from the HH nurse, documented the following:
"Patient [Resident #1] states [redacted] was thrown to the floor last night by attendant and feels totally helpless. . . . Medication history at ALF shows patient [Resident #1] did not receive [redacted] medications have not been given consistently over the past week and there Is [redacted] notes Indications [redacted] medication had run out but when Sn [HH nurse] check [redacted] medication box

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUROS DE SALVACION	**10405 THERESA PLACE NE ALBUQUERQUE, NM 87111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 30	A 033		

[redacted] both mediations were there. . . . Attendant stated that patient [Resident #1] has not been receiving [redacted]
4. Review of the Medication Administration Records (MAR) at the facility for Resident #1 revealed no MAR for October or December, 2010 [redacted] was admitted on [redacted]/10 and discharged on [redacted] 10). Review of the November, 2010 MAR revealed Resident #1 did not receive [redacted]
Visit Slip dated 11/17/10 from the HH nurse, documented, "according to attendant and verified looking at patient's medication log [redacted] patient was not given a [redacted] this morning."
5. Visit Slip dated 11/19/10 from the HH nurse, documented the following: [redacted]
E) Review of the "Progress Notes" at the facility revealed an entry by staff #9 documenting the following:
"[Resident #1] I came in and [redacted] had a [redacted] on [redacted] I don't know what happened, but [Resident #1] said [staff #15] was mean to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUROS DE SALVACION	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 31	A 033		

[redacted] and was saying [redacted] stuff to [redacted] [redacted] [Resident #1's [redacted] called and [Resident #1] told her the same thing. [HH nurse] came to see [redacted] and [redacted] also told her."

F) Review of records obtained by this surveyor from the Home Home Healthcare agency on resident #1 revealed additional visit slips where the following information was documented:
1. Visit Slip dated 11/22/10 from the HH nurse, documented the following:
"Sn [Home Health nurse] received a call from the ALF [facility] on SUNDAY 11-21-10 at 0730 stating the patients [Resident #1] BP [blood pressure] was high 180-100. Sn returned the phone call later that day and attendant stated patient [Resident #1] was upset during the time she had taken the BP [blood pressure] that morning and had not given the patient [Resident #1] [redacted] BP [blood pressure] medications yet that morning. Attendant agreed to check bp [blood pressure] again and reported back over the phone that the bp [blood pressure] was now [redacted]
"As a follow-up from the phone call concerning bp elevation over the weekend-Sn [Home Health Nurse] looked over the medication log and there were circles indicating patient did not receive [redacted] [redacted] for 2 days. There was notation indicating the medication needed refilling and that is why it was not given. Sn examined patients medication box and found a medication bottle that was empty but there was plastic sleeve containing a months worth of atenolol in patients medication box."
. . .
"Patient [Resident #1] states [redacted] is not going to participate in Thanksgiving meal because of unfriendly discussion with owner and night attendant [staff #15]."
G) Review of the Medication Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUROS DE SALVACION	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 32	A 033		

Records (MAR) at the facility for Resident #1 revealed no MAR for October or December, 2010 [redacted] was admitted on 1[redacted]/10 and discharged on [redacted] 10). Review of the November, 2010 MAR revealed [Resident #2] did not receive [redacted]

H) Review of the Drug Information Handbook for Nursing, 2007 revealed, "ATENOLOL . . . Use Treatment of hypertension . . ."

I) Review of the "Nursing 2010 Drug Handbook" revealed, "Atenolol Black Box Warning Avoid abrupt discontinuation of therapy. Withdraw drug gradually to avoid serious adverse reactions, such as severe exacerbations of angina, myocardial infarction, and ventricular arrhythmias even in patients treated only for hypertension."

J) Review of records obtained by this surveyor from the Home Home Healthcare agency on resident #1 revealed additional visit slips where the following information was documented:

1. Visit Slip dated 11/22/10 from the HH nurse, documented the following:
". . . Patient [Resident #1] states [redacted] has come up with a strategy to deal with the night employee that is so mean to [redacted] Patient [Resident #1] tried being so nice and smiling all the time last night and the employee didn't know what to do. . . ."

2. Visit Slip dated 11/24/10 from the HH nurse, documented the following for resident #1:
"BP [blood pressure] [redacted] for the past week. There is evidence that the [redacted] was not given twice a day as prescribed this week and it has been observed that patient [Resident #1] is not kept on a [redacted]. BP [redacted] BP recorded in VS record as [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUROS DE SALVACION	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 33	A 033		

Bp greater than [redacted] the past three days. There is a note written that the [redacted] medication is out [redacted] dated 11-23-10[redacted]] When patients [Resident #1] med box checked [redacted] there was 2 plastic blue sleaves of [redacted] the generic name of the medication was listed first with [redacted] written underneath. . . . There is a signature that the med was given the past three days. The signature is the owners [staff #16] who was in to care for patient yesterday afternoon after 5 PM according to attendant that is present here today. Attendant states the owner was not in facility the previous two days. [redacted] when SN arrived. Pt [Resident #1] had just awaken and had [redacted] on but [redacted] was empty. After switching [redacted] Patient did not have [redacted] on. Patient states it does not work anymore. Attendant demonstrated to SN that the [redacted] would not turn on and blue adapter for [redacted] was missing."

3. Visit Slip dated 11/26/10 from the HH nurse, documented the following for resident #2: "The attendant that was on was the attendant that had written 3 days ago that [redacted] mediation was out. . . . She stated the day attendant had pointed out the highlighted [redacted] to her when she came on today and she had given the patient [Resident #1] [redacted] evening dose this evening. She stated she did not give the patient [redacted] when she had made a note that the [redacted] was out or the day after."

K) Review of the Medication Administration Records (MAR) at the facility for [Resident #1] revealed no MAR for October or December, 2010 [redacted] was admitted on [redacted]/10 and discharged on [redacted] 10). Review of the November, 2010 MAR revealed resident #1 did not receive [redacted] morning dose of [redacted] on 11/1, 11/2, 11/3, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUROS DE SALVACION	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 34	A 033		

11/18/10. The initials that were circled were from staff #9. There were no notes as to why the [redacted] was not given. There were notes stating "out of med" for resident #1 PM dose of [redacted] on 11/14 and 11/24/10 from staff #11, however the morning dose was initialed as given on both of those days and the days that followed, signifying the supply of [redacted] was not out. The evening doses were initialed for 11/23, 11/24, and 11/25/10 with initials that had no identifying signature on the MAR and were not staff #9 or #11; however staff #11 had noted out of med," on 11/24/10. The initials appear to be the owner's as this is the only staff with those initials. Refer to the HH nurse visit slip dated 11/24/10, "Owner was not in the facility on 11/23/10 or 11/24/10".

L) Review of the Drug Information Handbook for Nursing, 2007 revealed, "NORVASC . . . Use Treatment of hypertension . . . "

M) Review of the "Nursing 2010 Drug Handbook" revealed, [redacted] Alert: Abrupt withdrawal of drug may increase frequency and duration of chest pain. Taper dose gradually under medical supervision."

N) Review of the November, 2010 MAR revealed [Resident #1] did not receive [redacted] on 11/01, 11/02, 11/03, 11/06, 11/07, and 11/08/10. There were notes from staff #10 dated 11/07/10 and 11/08/10 stating, "Out of med." All of the not given doses were initialed by staff #10. On 11/04 and 11/05/10 the [redacted] was initialed by staff #9 as given, signifying the facility was not out of the medication on 11/06, 11/07, and 11/08/10. If the medication had been refilled on on 11/04/10, there would have been a 30 day supply.

O) Review of the Drug Information Handbook for Nursing, 2007 revealed [redacted] Use Treatment of hypertension . . . "

P) Review of the "Nursing 2010 Drug Handbook" revealed, [redacted] PATIENT TEACHING . . .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUROS DE SALVACION	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 35	A 033		

Advise patient that stopping drug abruptly may cause severe rebound high blood pressure."
Q) Review of the "BARRON'S MEDICAL GUIDE Dictionary of Medical Terms, Fifth Edition," revealed, "hypertension . . . Severe hypertension damages the cardiovasclar system and frequently results in heart disorders or cardiovascular accidents [strokes]."

R) Review of records obtained by this surveyor from the Home Home Healthcare agency on resident #1 revealed additional visit slips where the following information was documented:
1) Visit Slip dated 12/08/10 from the HH nurse, documented the following for Resident #1:
". . . Patient [Resident #1] states [redacted] has a head ache . . . Patient [Resident #1] states that [redacted] has been told by the attendant ALF is all out of [redacted] Sn [Home Health nurse]examined patients medication box and found a bottle of [redacted] Medication record showed no [redacted] had been given since the first of December. Attendant on for shift and owner, was told by Sn that patient was complaining of a head ache. [Owner], stated that the patient often is just imagining that [redacted] has a head ache. [Owner], stated that in the past he had tried tricking the patient by telling the patient he had given the patient [redacted] and two hours later the patient asked him again for some [redacted] When [Owner], was asked if he had ever given the patient [redacted] he said yes. Sn told [Owner], that he needed to chart when he did give the patient [redacted]
There was no record of a BM [bowel movement], BP [blood pressure] or Weight since the first of December.
[Owner] given information how to reach [Records Clerk] in the medical records at the Home Health agency In [sic]order to obtain any records he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUROS DE SALVACION	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 36 needs regarding patient." . . . 2) One Time Evaluation Visit dated 12/08/10 from the Home Health agency's Physical Therapist (PT) documented the following: "Home safety evaluation. PT arrived at [facility] assisted living and [redacted] of pt. [Resident #1] opened door. Staff was not in immediate view of pt. PT met with [redacted] and pt. . . . Pt. [Resident #1] was asked to demonstrate chair, bed, toilet and shower transfer. Pt. [Resident #1] is able to rise from sit to stand from chair, bed, and toilet but requires SBA [stand by assistance] for poor safety awareness. Pt. rises from chair, bed and toilet without the use of [redacted] arms and does not feel the sitting surface on the back of [redacted] legs before [redacted] sits. [redacted] at risk for falling when sitting down. Pt. [Resident #1] gets into bed at the wrong end and almost hit [redacted] head on the foot board and required verbal cues for getting into bed at the headboard. . . . Pt. requires SBA for ambulation and verbal cues for O2 line safety. Facility staff was not available until after assessment and the gentleman who presents himself as the owner reports that the pt. is consistently supervised. PT explained that pt. [Resident #1] requires SBA which is defined as standing next to pt. [patient] when pt. is actively mobile, and supervision can [redacted] be from 50 feet away which is not adequate for the safety of this patient [Resident #1] . As an example, PT pointed out to caregiver that pt. [Resident #1] is stepping on bundles of [redacted] and his [owner] response was that the pt. [Resident #1] had not fallen yet. Caregiver [owner] also points out the pt. [Resident #1] Is [redacted] prone to wandering, especially at night, and reports that staff is supervising pt [Resident #1]. Home safety assessment of this pt. [Resident #1] is that pt. requires SBA for all activity that requires the pt. to	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUROS DE SALVACION	**10405 THERESA PLACE NE ALBUQUERQUE, NM 87111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 37 be mobile such as transfers and ambulation secondary [redacted] to mentation. Pt. [Resident #1] is at high fall risk secondary to mentation and [redacted] 3) One Time Evaluation Visit dated 12/10/10 from the Home Health agency's Occupational Therapist (OT) documented the following: ". . . Pt [Resident #1] was amb [ambulating (walking)]in home without sba [stand by assistance]. Pt [Resident #1] ambulated over [redacted] without awareness of its location or safety risk. Home fast [redacted] completed with 2 negative indicators. . . . Pt [Resident #1] required verbal cues and physical assistance to adjust [redacted] to allow for safe amb with sba. . . . Pt [Resident #1] requires sba to [redacted] cga [caregiver assistance] and some verbal cues for all activities to decrease fall risk, and assure that the task Is [redacted] done safely and correctly secondary to decreased mentation, poor safety awareness and problem solving." 4) Visit Slip dated 12/13/10 from the HH nurse, documented the following for resident #2: . . . "[Home Health nurse] Discussed with director [owner], facilities ability to provide low sodium foods to patient [Resident #1]. Director stated he does not add salt to patients foods. When asked what the patient had eaten the last 24 hours director stated patient had cup of coffee and sweet roll wife had brought for patient for breakfast, that patient does get offered eggs and sausage for breakfast, grilled cheese sandwich for lunch and that patient had been receiving mexican foods at night. Sn [Home Health nurse] instructed director that the cheese, sausage, and mexican food have high sodium content which the director acknowledged. . . . Director stated patient has swings in his mood	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUROS DE SALVACION	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 38	A 033		

from anger to complete calmness. Review of medication sheet shows patient has received resperdone twice in the last 13 days. Sn asked director why patient was not offerred this medication daily. Director stated that the patient was 200 lb and this dose was not enough [redacted] to make a difference in the patients behavior. Director states that he believes [sic] a lot of the patients [redacted] behavior can be controlled by the approach taken. Sn asked director why there was not a care plan yet on this patient and if he had gotten medical records from Home Health agency since SN had provided contact person and phone number for medical records. Director states he just has not had time besides he knew the patient now that he had been the one taking care of him the past few days. Sn pointed out to director that if there is someone other than himself caring for this patient that there should be a plan of care. Director acknowledged Sn as being correct."

4) Review of the facility's monthly menu at the facility revealed 3 meals a day for 31 days, for a total of 93 meals. Of the 93 meals listed on the menu, 69 of the meals had at least one entry that is high in sodium, 12 had at least 2 entrees that were high in sodium, and 51 had high sodium foods for the main dish. There were no alternatives listed on the menu.

5) Visit Slip dated 12/21/10 from the HH nurse, documented the following for Resident #1: "Owner of ALF is only attendant on duty at this time. Asked attendant if patient had received any tylenol this morning for HA [head ache]. Attendant stated no he gave patient all his regular medications without the [redacted] even though patient asked for [redacted]
There is still no careplan in patients [redacted] chart. Attendant [owner] states that his FAX machine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUROS DE SALVACION	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 39	A 033		

did not work last week and he was unable to get the HH medical records department to FAX patients [Resident #1] medical records to him. Attendant [owner] states he will try to obtain records this week. According to [redacted] who called Sn [Home Health nurse] prior to Sn visit, patient [Resident #1] is scheduled to be transferred to [name] long term care tomorrow."
S) Review of staff records revealed no training records and Medication Assistance Certificates for staff #9 through #15.
T) Tour of the facility on 12/14/10 at 9:15 am, resident #1 was observed standing on the front porch alone with [redacted] shut in the front door. Owner was inside the facility with the other two residents and was the only staff on duty.
U) In an interview with Resident #1 on 12/14/10 at 9:20 am, the following conversation took place:
Surveyor: "How are you doing?"
Resident #1: [no answer]
Surveyor: "How do you like living here?"
Resident #1: "Why would I like living here?" [seemed irritated]
Surveyor: I was just making conversation.
Resident #1: [long pause] "Well, guess [redacted] okay to do that." [Voice sounded angry and facial expression looked angry.]
Surveyor: Have a nice day. [This surveyor decided not to continue interview.]
V) In a telephone interview with the HH nurse on 01/04/11 at 3:00 pm, the HH nurse acknowledged the following: There were 3 or 4 caregivers. [Staff #11 was there in the afternoon and [staff #9] was there in the morning. Neither were compliant with resident #1's medications. The HH nurse stated, "I believe the caregivers are trying, but they are not trained." She further acknowledged the Blood pressure checks were not being done, and they were feeding [redacted] [resident #1] ham, pork, grilled

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A 033	Continued From page 40	A 033		

cheese, and bacon. She confronted the owner, [staff #16's name] and stated, "He is not well versed and there no oversight."
W) In a telephone interview with staff #10 on 02/08/11 at 3:00 PM, staff #10 acknowledged the following: resident #1 had trouble adjusting, would get agitated sometimes, needed constant supervision, did not care for staff #15, and said staff #15 was mean to [redacted] Staff #10 stated, "On my shift [redacted] [resident #1] was getting [redacted] meds. I worked graveyard shift." When asked if there was any documents at the facility with resident #1's diagnosis, staff #10 answered, "Did not have any diagnosis or none I knew of write off hand. I know [redacted]
X) In a telephone interview with staff #9 on 02/08/11 at 9:39 am, staff #9 acknowledged she did not receive any training from the facility or have a medication assistance certificate and she did assist with medications at the facility.
Y) In a telephone interview with staff #13 on 02/09/11 at 9:34 am, staff #13 acknowledged the following: she had worked at the facility from approximately the third week in October, 2010 to mid November, 2010, had been back at the facility working for about 3 weeks now, had never been offered any training at the facility, and did not have a medication assistance certificate. When asked if resident #1 was a resident at the facility when she previously worked there, staff #13 stated, "Yes, [redacted] was terrible, threw [redacted] at us [redacted] wanted everyone to jump [redacted] argue and fight. I did not feel like [redacted] belonged there. [redacted] would try to get over fence, stand in chair, and sit on fence." When staff #13 was asked if there was any documentation of diagnosis for resident #1, she answered, [redacted] [resident #1's [redacted]] and owner told me everything. House was so chaotic with [redacted] [resident #1] there. [redacted] should not have been in

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A 033	Continued From page 41 this house. [Name of owner] or [redacted] [resident #1s [redacted]] told me [redacted] [resident #1] had [redacted] Z) In an interview with owner on 12/14/10 at 1:45 pm, this surveyor gave a list of documents needed for record review, which included the following: resident #1 record of Admission/Retention team meeting, Physician's History and Physical, visit slips/progress notes from the Home Health agency, and any incident reports. At the time of exit on 01/05/11 the facility had not provided any of these documents. AA) In an interview with the owner on 01/05/11 at 1:45 pm, this surveyor asked for the documents listed above and the owner commented, "I [redacted] still waiting on documents. Paperwork just needed for you[redacted] When asked if resident #1 was on a regular diet, the owner said, "Yes." When asked if he reported resident #1's fall and resulting injury to HFL&C, the owner answered, "Try to recall, when get up from bed, broke shelf on head board[sic]. [redacted] never fell, we actually saw broken [redacted] Nobody witnessed." When asked if he knew resident #1's diagnosis, owner staff #16 answered, [redacted] When asked if he knew resident #1 had tested positive for [redacted] the owner answered, "Did not know of [redacted] BB) Conclusion: Resident #1 was not receiving medications as prescribed resulting in dangerous behaviors and dangerously high blood pressure. [redacted] was not on a low salt diet as needed for the high blood pressure. [redacted] was not receiving Stand By Assistance and did encounter a injury due to this. Resident #1 [redacted] was not monitored which caused [redacted] to be dangerously low on at least 2 occasions.	A 033		

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A 035	Continued From page 42	A 035		
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	A 035		

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A 035	Continued From page 43 PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is	A 035		

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A 035	Continued From page 44 to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. 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:	A 035		

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A 035	Continued From page 45 (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.82.35 MEDICATIONS: . . . No medication . . . or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner . . . Based on record review and interview the facility failed to have orders from a physician, physician assistant or nurse practitioner for 1 of 2 residents records reviewed (#1). The findings are: A) Review of records for resident #1 revealed a medication list with a home health agency name at the top of the first page and there was no hand	A 035		

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A 035	Continued From page 46 written signature or electronic signature from a primary care physician, a nurse practitioner or a physician's assistant. There were no other medication lists or medication orders in the records for resident #1. Records also revealed resident #1 was not receiving medications as prescribed. B) During an interview with owner on 12/15/10 at 11:45 am, when this surveyor offered to review resident #1's record with him, owner had no comment. C) During an interview with owner on 1/5/11 at 1:45, this surveyor asked why resident #1 had not been receiving [redacted] medications as prescribed. Owner replied, "I fired all of them." Refer to 7.8.2.35 G. Medication assistance record (MAR). . . . the facility shall have a MAR that documents the details of the residents' medication . . . Based on record review and interview, the facility failed to have a MAR for the months of October, 2010 and December, 2010 for 1 of 2 residents charts reviewed (#1). This deficient practice has the potential for medication errors, missed medications, and overmedicating. The findings are: A) Review of records for resident #1 revealed [redacted] was admitted to the facility on [redacted]/10 and discharged on [redacted]/10. There was no MAR for the months of October, 2010 and December, 2010 in resident #1's chart. B) In an interview with the owner on 12/15/10 at 11:45, this surveyor asked for the MAR's for the months of October, 2010 and December, 2010 for resident #1. At the time of exit on 1/5/10 at 1:45 pm, these documents had not been provided to this surveyor. Refer to 7.8.2.35 G. Medication assistance	A 035		

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A 035	Continued From page 47 record (MAR). . . . The information in the MAR shall include: . . . (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. Also refer to 7.8.2.35 H. No medication shall be stopped or started without specific orders from the primary care physician. Based on record review and interview the facility failed to document the reason for medications not being given for 1 of 2 residents charts reviewed (#1). This deficient practice has the potential for unwanted and dangerous health outcomes for resident #1. The findings are: A) Review of the November, 2010 MAR revealed resident #1 did not receive [redacted] as needed on 11/04, 11/05, 11/09, 11/10, 11/11, 11/12, 11/14, 11/22, 11/26, and 11/30/10. Review of Physician's orders obtained from the Home Health agency providing nursing for resident #1 revealed. [redacted] Patient is presently taking one tablet in the afternoon with therapeutic effect [redacted] B) Review of the web site, "Medline Plus," revealed the following for [redacted] "Why is this medication prescribed? [redacted] is used to treat the symptoms of [redacted] in adults and teenagers 13 years of age and older. It is also used to treat episodes of [redacted] in adults and in teenagers and children 10 years of age and older with [redacted]	A 035		

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A 035	Continued From page 48 [redacted] is also used to treat [redacted] such as [redacted] in teenagers and children 5-16 years of age who hav [redacted] is in a class of medications called [redacted] It works by changing the activity of certain natural substances in the brain." C) In an interview with staff # 13 on 02/09/11 at 9:34 am, staff #13 was asked if resident #1 was a resident at the facility when she worked there. She answered, "Yes, [redacted] was terrible, threw [redacted] at us [redacted] wanted everyone to jump [redacted] argue and fight. I did not feel like [redacted] belonged there. [redacted] would try to get over fence, stand in chair, and sit on fence." D) Review of the November, 2010 MAR revealed resident #1 did not receive [redacted] evening dose on 11/01, 11/14, and 11/24/10. Resident #1 did not receive [redacted] morning dose of [redacted] on 11/19 and 11/20/10. The only note was from staff #11 dated 11/14/10 stating, "Out of Med." E) Review of the Drug Information Handbook for Nursing, 2007, page 119, revealed, "ATENOLOL . . . Use: Treatment of hypertension . . ." F) Review of the Nursing 2010 Drug Handbook, page 358, revealed, "Atenolol . . . Black Box Warning: Avoid abrupt discontinuation of therapy. Withdraw drug gradually to avoid serious adverse reactions, such as severe exacerbations of angina, myocardial infarction, and ventricular arrhythmias even in patients treated only for hypertension."	A 035		

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A 035	Continued From page 49 G) Review of a visit slip by the home health nurse dated 11/22/10 revealed the [redacted] was available at the facility on 11/1, 11/14/, 11/19, and 11/20/10. H) Review of the November, 2010 MAR revealed resident #1 did not receive [redacted] morning dose of [redacted] on 11/1, 11/2, 11/3, and 11/18/10. There were no notes as to why the [redacted] was not given. There were notes stating "out of med" for resident #1 PM dose of [redacted] on 11/14 and 11/24/10 from staff #11, however the morning dose was initialed as given on both of those days and the days that followed, signifying the supply of [redacted] was not out. I) Review of the Drug Information Handbook for Nursing, 2007 page 79, revealed, "Amlodipine, U. S. Brand Names Norvasc . . . Use Treatment of hypertension . . ." J) Review of the "Nursing 2010 Drug Handbook, page 310, revealed, "Norvasc . . . Alert: Abrupt withdrawal of drug may increase frequency and duration of chest pain. Taper dose gradually under medical supervision." K) Review of Visit Slip dated 11/24/10 from the home health nurse documented the following for resident #1: "BP [Blood Pressure] [redacted] for the past week. There is evidence that the Norvasc was not given twice a day as prescribed this week and it has been observed that patient [resident #1] is not kept on a low sodium diet restriction. . . . BP [redacted] BP recorded in VS record as [redacted] greater than [redacted] the past three days. There is a note written that the norvasc medication is out [redacted] dated 11-23-10 [redacted] When patients med box checked [redacted] there was 2 plastic blue sleaves of [redacted] the generic name of the medication was listed first	A 035		

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A 035	Continued From page 50 with Norvasc written underneath. . . . There is a signature that the med was given the past three days. The signature is the owners who was in to care for patient yesterday afternoon after 5 PM according to attendant that is present here today. Attendant states the owner was not in facility the previous two days." L) Review of the November, 2010 MAR revealed resident #1 did not receive [redacted] on 11/01, 11/02, 11/03, 11/06, 11/07, and 11/08/10. There were notes from staff #10 dated 11/07/10 and 11/08/10 stating, "Out of med." On 11/04 and 11/05/10 the [redacted] was initialed by staff #9 as given, signifying the facility was not out of the medication on 11/06, 11/07, and 11/08/10. M) Review of the Drug Information Handbook for Nursing, 2007, page 393, revealed [redacted] N) Review of the Nursing 2010 Drug Handbook, page 368, revealed, [redacted] O) Review of the Visit Slip dated 12/08/10 from the home health nurse documented the following for resident #1: ". . . Patient [resident #1] states [redacted] has a head ache . . . Patient states that [redacted] has been told by the attendant ALF [assisted living facility] is all out of [redacted] Sn [home health nurse] examined patients medication box and found a bottle of [redacted] Medication record showed no [redacted] had been given since the first of December. [owner], attendant on for shift and owner, was told by Sn that patient was complaining of a head ache. [Owner] stated that the patient often is just imagining that [redacted] has a head ache. [Owner]	A 035		

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A 035	Continued From page 51 stated that in the past he had tried tricking the patient by telling the patient he had given the patient [redacted] and two hours later the patient asked him again for some [redacted] When [Owner] was asked if he had ever given the patient [redacted] he said yes. Sn told [Owner] that he needed to chart when he did give the patient [redacted] P) In a telephone interview with the home health nurse on 01/04/11 at 3:00 pm, the home health nurse acknowledged the following: There were 3 or 4 caregivers. Staff #11 was there in the afternoon and staff # 9 was there in the morning. Neither were compliant with resident #1's medications. The home health nurse stated, "I believe the caregivers [staff] are trying, but they are not trained."	A 035		
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.	A 070		

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	2255	A. BUILDING: _____ B. WING _____	C 01/05/2011

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MUROS DE SALVACION	**10405 THERESA PLACE NE ALBUQUERQUE, NM 87111**

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A 070	Continued From page 52 [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.70 INCORPORATED AND RELATED RULES AND CODES: E. Employee Abuse Registry 7.1.12 NMAC. TITLE 7 HEALTH CHAPTER 1 HEALTH GENERAL PROVISIONS PART 12 EMPLOYEE ABUSE REGISTRY 7.1.12.1 ISSUING AGENCY: Department of Health. [7.1.12.1 NMAC - N, 01/01/2006] 7.1.12.2 SCOPE: This rule applies to a broad range of New Mexico providers of health care and services and employees of these providers who are not licensed health care professionals or certified nurse aides. This rule requires that providers check with the registry and avoid employing an individual on the registry. This rule provides for the investigation and determination of complaints alleging abuse, neglect or exploitation of recipients of care or services by employees. This rule further requires listing employees with substantiated registry-referred abuse, neglect or exploitation on the registry, following an opportunity for a hearing. This rule supplements other preemployment screening requirements currently applicable to health care providers, such as the requirement for criminal history screening of caregivers employed by care providers subject to the Caregiver Criminal History Screening Act, NMSA 1978 Sections 29-17-1 et seq. and that Act ' s implementing rule, 7.1.9 NMAC. It also supplements requirements for pre-employment screening of certified nurse aides applicable to nursing facilities pursuant to	A 070		

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A 070	Continued From page 53 42 CFR Sections 483.75(e) and 488.335; and 16.12.20 NMAC. This rule does not address the consequences of abuse, neglect, or exploitation for which a provider, as distinguished from an employee, is responsible. [7.1.12.2 NMAC - N, 01/01/2006] Based on record review and interview, the facility failed to make pre-employment inquiry to the Employee Abuse Registry (EAR) for 7 of 7 staff (#9 through #15). This deficient practice has the potential to affect the health and safety of residents. The findings are: A) Review of files for staff #9 through #15 revealed no documentation of inquiry to the Employee Abuse Registry. B) In an interview with the owner on 12/15/10 at 11:45, this surveyor asked for the documentation of inquiry to the Employee Abuse Registry for all staff. At the time of exit on 1/5/10 at 1:45 pm, these documents had not been provided to this surveyor. Refer to 7.8.2.70 INCORPORATED AND RELATED RULES AND CODES: . . . F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in	A 070		

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A 070	Continued From page 54 a timely and accurate manner. B. Training Curriculum: The licensed health care facility and community based service provider shall provide all employees and volunteers with a written training curriculum on incident policies and procedures for identification, and timely reporting of abuse, neglect, misappropriation of consumers' property, and where applicable to community based service providers, unexpected deaths or other reportable incidents, within thirty (30) days of the employees ' initial employment, and by annual review not to exceed twelve (12) month intervals. The training curriculum may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the licensed health care facilities or community based service provider ' s facility. Training shall be conducted in a language that is understood by the employee and volunteer. C. Incident Management System Training Curriculum Requirements: (1) The licensed health care facility and community based service provider shall conduct training, or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum that includes but is not limited to: (a) an overview of the potential risk of abuse, neglect, misappropriation of consumers' property; (b) informational procedures for properly filing the division's incident management report form; (c) specific instructions of the employees ' legal responsibility to report an incident of abuse, neglect and misappropriation of consumers ' property. (d) specific instructions on how to respond to abuse, neglect, misappropriation of consumers ' property;	A 070		

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A 070	Continued From page 55 (e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, misappropriation of consumers' property; and (f) where applicable to employees of community based service providers, informational procedures for properly filing the division's incident management report form for unexpected deaths or other reportable incidents. (2) All current employees shall receive training within ninety (90) days of the effective date of this rule. (3) All new employees shall receive training within thirty (30) days of the employees initial hire date. D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. E. Consumer and Guardian Orientation Packet: Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The	A 070		

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A 070	Continued From page 56 licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer ' s file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation. 7.1.13 NMAC 6 F. Posting of Incident Management Information Poster: All licensed health care facilities and community based service providers shall post two (2) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. All licensed health care facilities and community based service providers operating sixty (60) or more beds shall post three (3) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. The posters shall be posted where employees report each day and from which the employees operate to carry out their activities. Each licensed health care facility or community based service provider shall take steps to insure that the notices are not altered, defaced, removed, or covered by other material. [7.1.13.10 NMAC - N, 02/28/06] Refer to 7.1.13. A, B, C, & D Based on record review and interview the facility	A 070		

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A 070	Continued From page 57 failed to have an incident management system, an incident reporting training for staff, an incident reporting training curriculum, or training documentation. This deficient practice has the potential to affect of the residents at the facility. The findings are: A) Review of facility records revealed no incident management system, incident reporting training for staff, incident reporting training curriculum, or training documentation. B) In an interview with owner on 12/14/10 at 1:45 pm, this surveyor asked owner for all incident report trainings, incident reporting curriculum, and training documentation for reviewing alleged complaints and incidents. The owner's only reply was, "No incidents." At the time of exit on 01/05/11 none of these documents had been provided. Refer to 7.8.2.70 INCORPORATED AND RELATED RULES AND CODES: D. Caregivers Criminal History Screening Requirements, 7.1.9 NMAC Refer to 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: A. through G. Based on record review and interview the facility failed to meet the requirements for the Caregivers Criminal History Screening for 6 of 7 staff (staff #9 through 14). This deficient practice has the potential to affect the health and safety of the residents. The findings are: A) Review of files for staff #9 through #14 revealed no documentation of fingerprinting, application, fees paid, clearance letter, or any other documentation. Records revealed all 6 staff (#9 through #14) had worked in the facility alone and unsupervised.	A 070		

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A 070	Continued From page 58 B) In a telephone interview with former staff #9 on 02/08/11 at 9:39 am, staff #9 acknowledged the facility never had her fingerprinted. C) In a telephone interview with former staff #13on 02/09/11 at 9:34 am, staff #13 acknowledged the following: she had worked at the facility from approximately the third week in October, 2010 to mid November, 2010, had been back at the facility working for about 3 weeks now, and had never been fingerprinted. D) In an interview with the owner on 12/15/10 at 11:45, this surveyor asked for the documentation for the Caregivers Criminal History Screening Requirements for all staff. At the time of exit on 1/5/10 at 1:45 pm, these documents for staff #9 through #14 had not been provided to this surveyor.	A 070		