

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2007
NAME OF PROVIDER OR SUPPLIER CASA DEL VALLE I			STREET ADDRESS, CITY, STATE, ZIP CODE 2111 RAVEN LANE SW ALBUQUERQUE, NM 87105		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A19	7 NMAC 8.2.19 ADMISSIONS 7.8.2.19 ADMISSIONS: No resident shall be admitted or retained who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. EXCEPTION: Maternity Shelters may accept residents below the age of eighteen (18). A. ADMISSION INTERVIEW. The Director of the facility or a designee responsible for admission and retention decisions, shall meet with the resident or the resident's agent or guardian, if the resident lacks decision-making capacity, and shall provide the resident with: (1) The facility's program narrative. (2) The facility's rules. (3) The facility's admission agreement, including costs and charges, refund provision, and contract termination policies. (4) The facility's bed hold policy. (5) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (6) A written description of the legal rights of the residents translated into another language, if necessary. (7) The facility's staffing pattern. B. RESTRICTIONS ON ADMISSIONS: Adult residential care facilities shall not admit or retain individuals requiring continuous nursing care. Conditions or circumstances that usually require continuous nursing care, may include, but not limited to the following: (1) Ventilator dependency. (2) Pressure sores where skin loss penetrates beyond the skin, and into deeper tissue or bone, which are classified as Stage III or IV. (3) Intravenous therapy or injections directly into the vein.	A19	A team meeting with B. Scherke as soon as possible and the Licensing Authority will be notified within 5 days of the completion of the team process in writing to include evidence of the teams consideration of items 7-8-2 19C(A) through 7-8-2 19C(d) before June 10, 2007 to be corrected. This requirement will be met by the Administrator for all future retention exceptions		



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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X6) DATE

6899

12Z311

If continuation sheet 1 of 29

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A19	Continued From page 1 (4) Airborne infectious disease, in a communicable state, including tuberculosis, but excluding infections such as the common cold. (5) Any condition requiring either physical or chemical restraints. (6) Nasogastric tubes / gastric tubes. (7) Tracheostomy care. (8) Individuals presenting an imminent physical threat or danger to self or others. (9) Individuals whose physician certifies that placement is no longer appropriate. C. ADMISSION/RETENTION EXCEPTIONS: 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 to remain in the facility, and the facility wishes to re-admit or retain the resident, the facility must: (1) Convene a team, comprised of: (a) The facility director. (b) The resident. (c) The resident's agent, guardian or surrogate decision maker. (d) The resident's advocate, such as the resident's case manager, Ombudsman, or social worker. (e) If the treating physician is unable to meet with the team, then consultation and recommendations via phone is acceptable. (f) Other appropriate health care professionals. (2) The team shall jointly determine if the resident should be admitted or allowed to remain in the facility. The team must approve a individual service plan that meets the specific needs of the resident. Such team approval must be in writing, signed and dated by all team members, must be maintained in the resident's record, and must: (a) Be based upon a individual service plan which identifies the resident's specific needs	A19		

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A19	Continued From page 2 and addresses the manner that such needs will be met. (b) Ensure that the facility has and will maintain an evacuation rating of prompt or slow as determined by the Fire Safety Equivalency System (FSES). (c) Be based upon an assessment of the health, safety and well-being of the other facility residents. (d) Assess the impact that meeting the specific needs of the resident as set out in the individual service plan will have on the staff and on the other residents. (3) Notify the Licensing Authority within five (5) days of the completion of team approval. Such notification of team approval must be submitted in writing and include evidence of the team's consideration of items 7.8.2.19C2(a) through 7.8.2.19C2(d) above. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.19 NMAC - Rn. 7 NMAC 8.2.19, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.19C. Based on record review and interview, the facility failed to convene a team to determine if a resident requiring a greater degree of care than the facility would normally provide should be allowed to remain in the facility for 1 of 2 sampled residents (50%). The findings are: A. Review of R1 's resident records revealed that R1 began receiving hospice services after admission. However, there was no evidence that a team had been convened to jointly determine whether R1 should be allowed to remain in the facility.	A19			

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A19	Continued From page 3 B. During the exit-interview with the Administrator on 5/14/07 at 3:30 p.m., the Administrator acknowledged that R1 began receiving hospice services after admission but the facility failed to convene a team to determine if R1 should be allowed to remain in the facility.	A19		
A21	7 NMAC 8.2.21 ADMISSION RECORDS 7.8.2.21 ADMISSION RECORDS: A. In addition to the resident record requirements, the facility must maintain for each resident, the following: B. The resident's written acknowledgement that the facility, prior to or at the time of admission, provided the resident with, and answered any resident questions regarding: (1) The facility's program narrative. (2) The facility's rules. (3) The facility's admission agreement, including costs and charges, refund provision, and termination policies. (4) The facility's bed hold policy. (5) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. Such law includes: Uniform Health Care Decisions Act, Section 24-7A-1 et. seq., NMSA 1978, as amended; New Mexico Durable Power of Attorney for Health Care Decisions, Section 45-5-501, et. seq., NMSA 1978, as amended; New Mexico Living Will and Declaration under the Right to Die Act Section 24-7-1 et seq., NMSA 1978, as amended. [4-7-97, 7.8.2.21 NMAC - Rn, 7 NMAC 8.2.21, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.21B.(4-5)	A21	① A Bed Hold Policy will Be developed and provided to Residents R1 and R2. An Acknowledgment Form will Be maintained in the Residents Record. ② Residents will Be provided with material Regarding Residents Healthcare Rights under N.M. Law and an Acknowledgment Form will (over)	

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A21	Continued From page 4 Based on record review and interview, the facility failed to maintain the resident's written acknowledgement that the facility, prior to or at the time of admission, provided the resident with and answered questions regarding the facility's bed hold policy and resident's health care rights under NM law (Uniform Health Care Decisions Act, NM Durable Power of Attorney for Health Care Decisions, NM Living Will and Declaration under the Right to Die Act) for 2 of 2 sampled residents (100%). The findings are: A. Review of R1 and R2's resident records revealed no written acknowledgement that the facility provided R1 and R2 with, and answered questions regarding, the facility's bed hold policy and resident's health care rights under NM law. B. During the exit-interview with the Administrator on 5/14/07 at 3:30 p.m., the Administrator acknowledged that R1 and R2's resident records contained no written acknowledgments that the facility provided R1 and R2 with, and answered questions regarding, the facility's bed hold policy, and resident's health care rights under NM law.	A21	<i>Be Maintained in the Residents Record Correction Completed 6-15-07</i>	
A22	7 NMAC 8.2.22 RESIDENT RECORDS 7.8.2.22 RESIDENT RECORDS: A. RESIDENT RECORDS, CONTENTS: A record for each resident shall be maintained with specific information required. Entries in each resident's record shall be legible, dated, and authenticated by the signature of the person making the entry. Resident records must include: (1) Admission records as set out in Section 7.8.2.21 NMAC: (2) Within five (5) days of admission:	A22		

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A22	Continued From page 5 (a) An executed admission agreement. (b) A completed resident assessment form. (c) Any available, admission physical examination report by a licensed health care professional, which may include all discharge information from another facility. When admission follows within thirty (30) days discharge from an acute care hospital, the hospital history and physical report, and the hospital discharge summary may serve as an admission physical. (d) Names, addresses, relationship, and phone numbers of family members, and where appropriate, guardians, agents, and any surrogate decision makers. (3) Within thirty (30) days of admission: (a) A admission physical examination report by a licensed health care professional if an examination report was not available within five (5) days of admission. (b) Resident's name, age, recent photograph, social security number, marital status, date of birth, sex, address prior to admission, religion (optional), personal physician, dentist, social history and designated representative or other emergency contact person, language spoken and understood, legal documentation relevant to commitment and/or guardianship status, present medications, and diet required. (c) Any amendments to the admission agreement. (d) The current completed resident assessment form. (e) A completed and current individual service plan. (f) Entries by direct care staff, appropriate health care professionals, or others authorized to care for the resident. Entries shall be dated and signed by the person making the	A22	<i>The Administer will ensure that all Certified Staff will provide an authenticating signature for each MAR on their first scheduled work day of the month. Correction Completed 5-14-07 By Administer</i>		

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A22	Continued From page 6 entry and shall include significant information related to the individual service plan. (g) Entries providing 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 record in the resident record may be by copy of an incident/accident report, if the original incident/accident report is maintained elsewhere by the facility. (h) A medication record: Medications administered by licensed personnel and/or staff assisting with medications to include: listing all currently ordered medications by name, dosage, administration times; documenting by medication name, dosage, date, and time, each medication administered, with the initials of the individual who administered or assisted with the medication; documentation of errors, omissions, and side-effects of medications; and written consent by resident or guardian for staff to assisting with medications. (i) Date, time and progress note of health services provided by any contract agency. (j) 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. (k) Transfer forms completed, signed, and provided to accepting facility when resident is transferring to a hospital or another health care facility. (l) Documentation of disposition of the resident's personal effects and money or valuables deposited with the adult residential care	A22		

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A22	Continued From page 7 facility, upon death or transfer. B. RESIDENT RECORDS, MAINTENANCE: (1) Resident records shall be maintained and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy for maintaining, and confidentiality of resident records, including the authorized release of resident records. (3) Resident records must be maintained by the facility against loss, destruction, and unauthorized use for a period of not less than three (3) years from the date of discharge. (4) There must be a policy and procedure in place for record retention in the event of facility closure. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 7.8.2.22 NMAC - Rn 7 NMAC 8.2.22, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.22A. Based on record review and interview, the facility failed to maintain medication administration records (MAR 's) that were authenticated by the signature of the person making the entry for 2 of 2 sampled residents (100%). The findings are: A. Review of R1 and R2 's MAR 's revealed no signature of the person making the entries (initials only). B. During the exit-interview with the Administrator on 5/14/07 at 3:30 p.m., the Administrator acknowledged that she entered and initialed data on R1 and R2 's MAR 's but failed to provide an authenticating signature.	A22		

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A23	7 NMAC 8.2.23 FAC. REPORTS, RECS., P & PS & RULES 7.8.2.23 FACILITY REPORTS/RECORDS/POLICIES AND PROCEDURES/ AND RULES: A. REPORTS AND RECORDS: Each facility must keep the following reports, records, and policy and procedures on file at the facility and make them available for review upon request of the Licensing Authority: (1) Fire Inspection Report. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have fire inspection reports. (2) Copy of the last survey conducted by the Licensing Authority, adverse actions or appeals thereto, and complaints. (3) Copy of the latest survey from Environmental Health Authority (if applicable) regarding kitchen and food management and, if private sewage disposal, and private waste disposal. EXCEPTIONS: Adult residential care facilities with three (3) or fewer residents are not required to be inspected by Environmental Health Authority. Facilities exempted by the Environmental Health Authority having jurisdiction, are not required to have a survey on file provided the exemption letter is on file. (4) TB test results of staff or any of their family members living in the facility. (5) One (1) month of menus planned and as served. (6) Record of fire drills: A record of all fire drills conducted at the facility. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to hold or record fire drills. (7) Written emergency plans and policies and procedures for medical emergencies, power failure, fire or natural	A23	<i>ALL Current staff and Administrators have completed the Required Training for the following-</i> <i>1 Fire Safety Training</i> <i>2 Safe Food Handling</i> <i>3 Confidentiality of Records</i> <i>4 Infection Control</i> <i>5 Residents Rights</i> <i>6 Providing Quality of Care Based on Residents need.</i> <i>Correction Completed</i> <i>6-15-07</i>	

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A23	Continued From page 9 disaster. Such plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes and refuge areas, responsibilities of personnel. (8) Licensing regulations: A copy of these regulations (Requirements for Adult Residential Care Facilities, 7.8.2 NMAC). (9) Custodial Drug Permit: A valid Custodial Drug Permit issued by the State Board of Pharmacy for those facilities licensed pursuant to these regulations. EXCEPTION: Adult residential care facilities with only one (1) resident are not required to have a custodial drug permit. (10) Vaccination of pets in the facility. (11) Staff training. (a) At orientation and on-going. (b) Appropriate to staff responsibilities. (Assistance with medications, dietary, environmental...) (c) Fire safety. (d) First aid. (e) Safe food handling practices. (f) Confidentiality of records and resident information. (g) Infection control (including universal precautions and linen handling). (h) Resident rights. (i) Providing Quality Resident care based on current resident need. (j) Reporting requirements for Abuse, Neglect or Exploitation. (12) A copy of License. (13) Employee personnel records, including an application for employment, TB certificates, training records, and personnel actions. (14) A copy of all WAIVERS/VARIANCES granted by the Licensing Authority. (15) A copy of the floor plans as approved for licensure.	A23		

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A23	Continued From page 10 B. RULES: Prior to placement in or admission to a facility, a prospective resident or his/her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to but not limited to the following: (1) The use of tobacco and alcohol. (2) The use of the telephone. (3) Operation of television, radio, and stereo. (5) Use and safekeeping of personal property. (6) Meals. (7) Use of common areas. (8) Electric blankets or appliances used by residents. C. 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, (e.g., gas leaks, injuries, transportation, medications,...). (2) Method of keeping informed when residents go outside of the facility (e.g., sign-out sheets). (3) The handling or resident's funds, if the facility provides such services. (4) Reporting of incidents, including abuse, neglect, and exploitation. (5) Handling of complaints. (6) Staff and resident fire and safety training. (7) Smoking. (8) The facility's bed hold policy. (9) Admission agreement. (10) Admission records. (11) Resident records. (12) Program Narrative. (13) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make	A23			

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A23	Continued From page 11 advance directives. (14) Personnel policies. (15) Identifying and safeguarding resident possessions. (16) Securing medical assistance if a resident's own physician is not available. (17) NOTE FOR MATERNITY SHELTERS ONLY: In addition to the required policy and procedure topics listed above, Maternity Shelters shall have written policies and procedures regarding infant formula, feeding and equipment, and laundering of infant linen and diapers. (18) Staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles. (19) Staff training for employees who operate motor vehicles to transport residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.23 NMAC - Rn & A 7 NMAC 8.2.23, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.23A.(11)(b) Based on record review and interview, the facility failed to maintain onsite records of assistance with medication training for 1 of 4 total staff (25%). The findings are: A. Review of personnel files for S12 revealed no record of assistance with medication training. B. During the exit-interview with the Administrator on 5/14/07 at 3:30 p.m., the Administrator acknowledged that there was no record of assistance with medication training for S12. 7.8.2.23A.(11)(c)	A23	① The Administrator will maintain a record of all staff training and will be reviewed quarterly or as needed to ensure proper records. ② The Administrator will maintain a copy of each staff member's Employment Application in the staff member's Employee File - Correction Completed - 5/20/07	

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A23	Continued From page 12 Based on record review and interview, the facility failed to maintain onsite records of ongoing training in fire safety for 4 of 4 total staff (100%). The findings are: A. Review of personnel files for the Administrator, S11, S12, and S13 revealed no records of fire safety training. B. During the exit-interview with the Administrator on 5/14/07 at 3:30 p.m., the Administrator acknowledged that there were no records of fire safety training for the Administrator, S11, S12, and S13. 7.8.2.23A.(11)(e, f, g, h, i,) Based on record review and interview, the facility failed to maintain onsite records of ongoing training in safe food handling, confidentiality of records, infection control, resident 's rights, and providing quality care based on resident needs for 3 of 4 total staff (75%). The findings are: A. Review of personnel files for the Administrator, S11, and S12 revealed no records of training in the above topics. B. During the exit-interview with the Administrator on 5/14/07 at 3:30 p.m., the Administrator acknowledged that there were no records of training in safe food handling, confidentiality of records, infection control, resident 's rights, and providing quality care based on resident needs for the Administrator, S11, and S12. 7.8.2.23A.(13)	A23		

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A23	Continued From page 13 Based on record review and interview, the facility failed to maintain an employment application on file for 1 of 4 total staff (25%). The findings are: A. Review of personnel files for S12 revealed no record of an employment application. B. During the exit-interview with the Administrator on 5/14/07 at 3:30 p.m., the Administrator acknowledged that there was no employment application on file for S12.	A23		
A24	7 NMAC 8.2.24 PETS 7.8.2.24 PETS: Pets are permitted in a licensed facility, in accordance with the facility's rules. A. Pets are not permitted in the kitchen or food preparation areas. B. Pets shall be vaccinated in accordance with all state and local requirements and records of such vaccination shall be kept on file in the facility [7-11-86, 4-7-97; 7.8.2.24 NMAC - Rn, 7 NMAC 8.2.24, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.24B. Based on interview the facility failed to vaccinate pets in accordance with all state and local requirements and maintain records of such vaccinations on file in the facility. The findings are: A. During an interview with the Administrator on 5/14/07 at 10:00 a.m., the Administrator revealed that the facility had 1 dog (Rotweiler) that had not been vaccinated.	A24	<i>The Administrator will ensure that any and all pets will have a maintained record of their vaccination on file at the facility.</i> <i>Correction Completed 5/21/07</i>	

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A33	7 NMAC 8.2.33 REPORTING OF INCIDENTS 7.8.2.33 REPORTING OF INCIDENTS: A. The facility must insure that all suspected cases or known incidents of resident abuse, neglect, exploitation, and mistreatment are reported. A facility must 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 and Adult Protective Services (APS) by the next business day. In no instance may a facility delay a report to Adult Protective Services or to the Licensing Authority, while an internal investigation is being conducted. B. The facility is responsible for documenting all incidents, within five (5) days of the incident, and having on file, the following: (1) A narrative description of the incident. (2) Results of the facility's investigation. (3) The facility action, if any. [7-1-64, 9-15-70, 5-26-72, 7-11-86, 4-7-97; 7.8.2.33 NMAC - Rn 7 NMAC 8.2.33, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.33A. Based on records review and interview, the facility failed to report incidents or unusual occurrences which could threaten the health, safety, or welfare of the residents to the Licensing Authority and Adult Protective Services by the next business day. The findings are: A. Review of a facility incident report dated 9/25/06 revealed that R3 had fallen and was transported to the emergency room. B. Review of a facility incident report dated	A33	The Administration will ensure that all incidents requiring emergency and non emergency services law enforcement, natural expected death - Abuse, Neglect and Exploitation are Reported to the appropriate Agency within 24 hours and complete a narrative description including the results of the Facility's investigation and action, if any from this 6/15/07 forward.	

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A33	Continued From page 15 10/25/06 revealed that R1 was injured in a physical fight with another resident and the police were called. C. During the exit-interview with the Administrator on 5/14/07 at 3:30 p.m., the Administrator revealed that the facility did not report either incident to the Licensing Authority or Adult Protective Services.	A33		
A35	7 NMAC 8.2.35 CUSTODIAL DRUG PERMIT 7.8.2.35 CUSTODIAL DRUG PERMIT: Any facility licensed pursuant to these regulations who supervises the administration, self-administration, or safeguards medications for residents, must have a current custodial drug permit issued by the State Board of Pharmacy. EXCEPTION: Adult residential care facilities with one (1) resident are not required to have a custodial drug permit. A. PROCUREMENT, LABELING, AND STORAGE: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as required by the individual or specified by the individual's health care plan. The facility shall procure, label, and store medications for residents in a manner which shall be in compliance with state and federal laws. (1) All medications, including non-prescription drugs, will be stored in a locked compartment or in a locked room, as approved by the Board of Pharmacy, and the key will be in the care of the director or designee. (2) Internal medication must be kept separate from external medications. Drugs to be taken by mouth will be separated from all other dosage forms. (3) A separate locked compartment will	A35	<i>The Administrator will ensure that a consulting pharmacist will review the medication regimen of each resident quarterly and will maintain a record of each review.</i> <i>A consultant pharmacist has been contracted and will complete his first review before June 15, 2007</i>	

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A35	Continued From page 16 be available in the refrigerator for those items labeled "keep in refrigerator." The refrigerator temperature will be kept between thirty-five (35) and forty-five (45) degrees Fahrenheit. A thermometer is required to be kept in the refrigerator. (4) All medications, including non-prescription medications, must be stored in separate compartments for each resident and all medications will be labeled with the residents' names. (5) A resident may be permitted to keep his/her own medication in a secure place in his/her room for self-administration if the physician's report has deemed it appropriate that the resident do so. (6) The facility may not require the resident to purchase prescriptions from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes must comply with National Fire Protection Association (NFPA) 99. B. CONSULTING PHARMACIST: The facility shall maintain records demonstrating the consulting pharmacist provides the following: (1) Reviews the medication regimen as needed, but at least quarterly (every three (3) months), to determine that all medications and records are accurate and current. All irregularities must be reported to the Director of the facility and these irregularities must be acted upon. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation is provided on all aspects of pharmacy services in the facility, including reference information regarding side	A35			

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A35	Continued From page 17 effects and, when needed, physician consultation in cases involving the use of psychotropic medications. [7-1-64, 9-15-70, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.35 NMAC - Rn, 7 NMAC 8.2.35, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.35B.(1) Based on record review and interview, the facility failed to maintain records demonstrating that the consulting pharmacist reviewed the medication regimen at least quarterly (every 3 months) to determine that all medications and records are accurate and current. The findings are: A. Review of consulting pharmacist reports revealed that the pharmacist signed as having reviewed resident medication regimens on 5/30/06 and 12/1/06 (6 month gap). B. During the exit-interview with the Administrator on 5/14/07 at 3:30 p.m., the Administrator acknowledged that the consulting pharmacist did not review resident medication regimens every 3 months.	A35			
A36	7 NMAC 8.2.36 MEDICATIONS 7.8.2.36 MEDICATIONS: Medications will be administered or staff assistance with medications provided and documented in accordance with state and federal laws. A. Licensed health care professionals are responsible for the administration of medications. B. Facility staff may assist a resident with medications if written consent by the resident is given to the director of the facility or their	A36	① The Administrator will ensure that medication for Residents will be maintained by the facility in accordance with the New Mexico Board of Pharmacy Act, Drug and Cosmetics		

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A36	Continued From page 18 designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with medications. All staff assisting with medications shall have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications. C. 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 by the physician and entry into the resident's record. D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and side-effects. E. Medications prescribed for one resident shall not be used for another resident. F. The facility shall have a Medication Administration Record (MAR) documenting medications administered to residents, including over-the-counter medications. This documentation shall include: (1) Name of resident. (2) Date started. (3) Drug product name. (4) Dosage and form. (5) Strength of drug. (6) Route of administration (e.g. "by mouth"). (7) How often medication is to be taken. (8) Time taken and staff initials. (9) Dates when the medication is discontinued or changed. (10) The name and initials of all staff administering medications.	A36	① Act, Controlled Substance Act and the Board of Pharmacy Rules and Regulations. ② The Administrator will also ensure that ensure that the medication Custodial Policy and Procedures Manual is followed. ③ Outdated, Discontinued, and otherwise unusable drugs including controlled substances will be removed, entered on the discharged/discontinuation Log, stored in a separate, locked cabinet and destroyed by the Consultant Pharmacist. Destruction of odd or p/c drugs will	

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A36	Continued From page 19 G. Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting. H. PRN Medications: The use of PRN medications must be closely monitored and supervised by the facility and is based on one or more of the following conditions: (1) The resident is capable of determining when the medication is needed. (2) The resident's physician has provided detailed instructions to the pharmacy regarding the administering of the medication. The physicians instruction for a PRN medication shall include: (a) Symptoms that might indicate the use of the medication. (b) Exact dosage to be used. (c) The exact amount of medication to be used in a 24 hour period. (d) Directions as to what to do if the symptoms persist. (e) Possible interactions or side-effects that might occur. (f) Manufacturer's label information for directions if deemed adequate by the physician. I. The facility must report all medication errors to the physician. J. The facility shall develop and follow a written policy for unused, outdated, or recalled medications being kept in the facility. [7-1-64, 9-15-70, 7019074, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.36 NMAC - Rn, 7 NMAC 8.2.36, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.36C. Based on record review and interview, the facility started an over-the-counter medication without a	A36	Be the Responsibility of the Consultant Pharmacist Destruction of C.S. Drugs must be done in the Presence of proper Personnel of the Facility and the Consultant Pharmacist. Correction Completed - 5/23/07		

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A36	Continued From page 20 physician ' s order for 1 of 2 sampled residents (50%). The findings are: A. Review of R1 ' s physician ' s orders revealed no order for " butt paste. " However " butt paste " was listed on R1 ' s MAR. B. During an interview with the Administrator on 5/14/07 at 3:00 p.m., the Administrator acknowledged that there was no physician ' s order for R1 ' s " butt paste. " 7.8.2.36F. (1-10) Based on observation, record review and interview, the facility failed to document medications administered to residents on the medication administration record (MAR) for 1 of 2 sampled residents (50%). The findings are: A. Observation of R1 ' s medication container revealed a bottle of immodium. B. Review of R1 ' s MAR revealed no entry for immodium. C. Review of R1 ' s physician ' s orders revealed that R1 ' s physician discontinued loperamide (generic immodium) on 4/24/07 and prescribed immodium on 4/25/07. D. During an interview with the Administrator on 5/14/07 at 3:00 p.m., the Administrator acknowledged that R1 ' s physician prescribed immodium but the facility failed to enter immodium on R1 ' s MAR. The Administrator explained that, rather than create a new entry on R1 ' s MAR for immodium, she continued documenting medication administration under loperamide (the discontinued generic drug).	A36		

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A36	Continued From page 21 7.8.2.36J. Based on observation, record review and interview, the facility failed to ensure that it developed and followed a written policy for unused medications being kept in the facility. The findings are: A. Observation of facility policies and procedures revealed no written policy for unused medications being kept in the facility. B. Review of R1 's physician 's orders revealed that loperamide was discontinued on 4/24/07. However, an unused blister pack of loperamide was still present in R1 's medication container. C. During the exit-interview with the Administrator on 5/14/07 at 3:30 p.m., the Administrator acknowledged that R1 's loperamide was discontinued on 4/24/07 but was still present in R1 's medication container. The Administrator further acknowledged that the facility had no written policy for unused medications being kept in the facility.	A36	(A4) A Fire Safety Emergency system (FES) Resident Assessment will be maintained on all Residents at the time of Admission and every 6 months or as needed Correction Completed 5/23/07		
A41	7 NMAC 8.2.41 BUILDING CONSTRUCTION 7.8.2.41 BUILDING CONSTRUCTION: When construction of buildings, additions, or alterations to existing buildings are contemplated, plans, code analysis and specifications covering all portions of the work shall be submitted to the Licensing Authority for plan review and approval prior to beginning actual construction. When an addition or alteration is contemplated, plans for the entire facility must also be submitted. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to	A41	The Facility's Gas Heater was inspected on 11/10/06 Documentation is now present in Facility Correction Completed 5/15/07		

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A41	Continued From page 22 submit floor plans. A. Building construction and the fire resistance required shall be based upon the capacity of the facility and the residents ability to evacuate the building, in accordance with the Uniform Building Code and NFPA 101 (Life Safety Code). (1) Larger buildings, which are more difficult to evacuate, require more built-in fire protection than smaller buildings. Occupants who are more difficult to evacuate require more built in fire protection than occupants who are easy to evacuate. (2) Evacuation capability, in accordance with NFPA 101, Fire Safety Equivalency System (FSSES), must be determined before proceeding to identify applicable building requirements. Evacuation capability is not determined on the basis of that resident who is least capable to evacuate, but rather for the entire facility. (3) Facilities not capable of prompt evacuation may not house residents unless the building is constructed to provide protection to these residents. All facilities that are rated as impractical to evacuate shall be protected throughout by an automatic fire protection (sprinkler) system. Facilities that are rated impractical to evacuate and that do not comply with the more restrictive building standards may not continue to care for residents. (4) NEWLY LICENSED AND/OR CONSTRUCTED ADULT RESIDENTIAL CARE FACILITIES: Shall be protected throughout by an approved, automatic fire protection (sprinkler) system. EXCEPTION 1: Sprinklers shall not be required in facilities serving eight (8) or fewer residents maintaining prompt evacuation capability. (5) CURRENTLY LICENSED FACILITIES: Any facility currently licensed on the	A41			

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A41	Continued From page 23 date these regulations are promulgated and which provides the services prescribed under these regulations, but fails to meet all building requirements, may be granted a variance to continue to be licensed provided: (a) The facility was in compliance with codes and standards at the time of initial licensure. (b) Variances granted will not create a hazard to the health, safety, or welfare of residents and staff. (c) The facility maintains prompt evacuation capabilities. B. Minimum construction requirements shall be a twenty (20) minute fire resistance rating for all bearing walls and partitions, floor construction, roofs, columns, beams, girders and trusses. C. NUMBER OF STORIES: Facilities may be of any number of stories if they comply with Uniform Building Code and NFPA 101 (Life Safety Code), with respect to construction and ability of the residents to evacuate in a timely manner. (1) One story buildings may be of Type V-(000) construction if all residents are capable of prompt evacuation. (2) Two story buildings must be of at least one hour construction. Residents who are not capable of prompt evacuation may not be housed above the street-level unless the facility is protected by an approved automatic fire protection (sprinkler) system. (3) Three stories or more require the building to be protected by an approved automatic fire protection (sprinkler) system. D. ACCESS TO PERSONS WITH DISABILITIES: Consultation may be given to new facilities on access requirements upon submission of floor plans during the initial licensing process. With the exception of Adult	A41		

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A41	Continued From page 24 Residential Care Facilities with three or fewer residents, accessibility to persons with disabilities must be provided in all facilities in accordance with New Mexico Building Code and the American Disabilities Act and shall, as a minimum, include the following: (1) Main entry into the facility must provide wheelchair access. (2) Building must allow access to main living area and dining area. (3) At least one bedroom shall be provided a door clearance of thirty-four (34) inches (thirty six (36) inches is recommended) for wheelchair access. (4) One toilet and bathing facility is required a minimum door clearance of thirty-four (34) inches (thirty six (36) inches is recommended) for wheelchair access. This toilet and bathing area must provide a sixty (60) inch diameter clear space (turning radius for a wheelchair). (5) If ramps are provided to the building, a minimum slope of twelve (12) inches horizontal run for each one (1) inch of vertical rise is required. Ramps exceeding a six (6) inch rise shall be provided with handrails. (6) Landings at doorways must have a minimum five (5) foot by five (5) foot level area at the doorway to provide clear space for wheelchair maneuvering. E. PROHIBITION ON MOBILE HOMES: Trailers and mobile homes shall not be used for any part of any adult residential care facility caring for more than three (3) residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.41 NMAC - Rn, 7 NMAC 8.2.41, 8-31-00] This REQUIREMENT is not met as evidenced by:	A41		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A41	Continued From page 25 7.8.2.41A.(3) Based on record review and interview, the facility failed to ensure that it maintained a "prompt" evacuation rating by assessing fire evacuation capability of each of its current residents. The findings are: A. Record review of Fire Safety Equivalency System (FSSES) resident evacuation assessments revealed no assessments for 3 of 10 total residents, including 1 resident receiving hospice services (R1, R4, R5). B. During the exit-interview with the Administrator on 5/14/07 at 3:30 p.m., the Administrator acknowledged that FSSES resident evacuation assessments had not been conducted on R1 (hospice patient), R4, and R5.	A41		
A45	7 NMAC 8.2.45 HEATING, VENTILATION AND AIR-CONDITIONING 7.8.2.45 HEATING, VENTILATION AND AIR-CONDITIONING: A. Heating, air-conditioning, piping, boilers, and ventilation equipment must be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities must have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. B. The heating method used by the facility must provide a minimum temperature of seventy (70) degrees Fahrenheit in all rooms used by the residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device may be used for heating the facility.	A45	The Facility's Gas Heater was inspected on 11/10/06. Documentation is now present in the Facility. Correction completed 5/15/06	

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A45	Continued From page 26 Portable heating units shall not be used for heating the facility. All heating appliances must be permanently anchored and kept away from flammables such as curtains, bedcoverings, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or danger from electrical shock. D. Fireplaces and open flame heating are not permitted to be utilized in sleeping rooms. E. Gas fired water heaters must not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms. F. A facility must be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means. G. All openings to the outside air used for ventilation must be screened for the control of insects and rodents. Screen doors must be equipped with self-closing devices. H. A facility must be provided with a system for maintaining residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard or danger from electrical shock. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7-1-64, 9-15-70 9-24-76, 7-11-86, 4-7-97; 7.8.2.45 NMAC - Rn, 7 NMAC 8.2.45, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.45A. Based on record review and interview, the facility failed to provide documentation that its fuel-fired (gas) heater had been checked, tested, and maintained annually by qualified personnel. The findings are:	A45		

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A45	Continued From page 27 A. Record review provided no evidence that the facility's gas heater had been inspected annually by qualified personnel. B. During the exit-interview with the Administrator on 5/14/07 at 3:30 a.m., the Administrator acknowledged that she could not provide documentation that the gas heater had been inspected annually by qualified personnel.	A45		
A63	7 NMAC 8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING 7.8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff personnel of the facility must know the location of and be instructed in proper use of fire extinguishers and other procedures to be observed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff must be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways, and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident must upon being accepted into the facility be given an orientation tour of the facility to include, but not be limited to, the location of the exits, fire extinguishers, and telephones, and shall be instructed in action to be taken in case of fire or other emergency. D. Fire Drills: The facility must conduct at least one (1) fire drill each month: (1) Fire drills must be held at different	A63	The Administrator will ensure that fire drills are completed monthly and will maintain a record of all fire drills. The Administrator will complete monthly fire drills by the 1st week of each month. Correction Completed 5/15/07	

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A63	Continued From page 28 times of the day. (2) The fire alarm system or detector system in the facility shall be used in the conduct of fire drills. (3) In the conduct of fire drills, emphasis must be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of fire drills held must be maintained on file in the facility. Such record must show date and time of the drill, number of personnel participating in the drill, any problem noted during the drill and the evacuation time in total minutes. (5) The local fire department should be requested to supervise and participate in fire drills. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.63 NMAC - Rn, 7 NMAC 8.2.63, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.63D. Based on records review and interview, the facility failed to provide documentation that fire drills were conducted at least once a month. The findings are: A. Record review revealed no documentation of a fire drill during the month of March, 2007. B. During an interview with the Administrator on 5/14/07 at 10:15 a.m., the Administrator acknowledged that a fire drill was not conducted during the month of March, 2007.	A63		