Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5827	A. BUILDING _____ B. WING _____	02/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHED BY A WHITE DOVE ASSISTED LIVIN	1605 CARDENAS DRIVE NE ALBUQUERQUE, NM 87110

(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
A13	7 NMAC 8.2.13 GROUNDS FOR REVOCATION OR SUSPENSION OF LICEN 7.8.2.13 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES: A. When the Licensing Authority determines that an application for renewal of a license is to be denied, or that a license is to be revoked, the Licensing Authority shall provide written notification to the adult residential care facility, the residents of the adult residential care facility and the surrogate decision maker for the resident. B. A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following reasons: 1. Failure to comply with any provision of these regulations. 2. Failure to allow a survey by authorized representatives of the Licensing Authority. 3. Hiring or retaining any employee who has been convicted of a felony or misdemeanor related to abuse, neglect or exploitation, trafficking in controlled substances, criminal sexual penetration or related sexual offenses. 4. Misrepresentation or falsification of any information on application forms or other documents provided to the Licensing Authority. 5. Discovery of repeat violations of these regulations. 6. Failure to provide the required care and services as outlined by these regulations for the residents receiving care from the facility. 7. Exceeding licensed capacity.	A13		

Division of Health Improvement

Carmen D. Romero-Hueston — TITLE: Director/Owner — (X6) DATE: 5-1-07

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

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A13	Continued From page 1 8. Failure to provide an acceptable plan of correction. 9. Abuse, neglect or exploitation of any patient/client/resident by facility operator, staff or relatives of operator/staff. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 6-15-98; 7.8.2.13 NMAC - Rn, 7 NMAC 8.2.13, 8-31-00] This REQUIREMENT is not met as evidenced by: REFER TO 7.8.2.13 - GROUNDS FOR REVOCATION OF LICENCE BASED ON EXCEEDING LICENSED CAPACITY. BASED ON OBSERVATION AND INTERVIEW, THE FACILITY FAILED TO ENSURE THAT ITS LICENSED CAPACITY WAS NOT EXCEEDED. THE FINDINGS ARE: DURING A TOUR OF THE FACILITY, IT WAS NOTED THAT THAT THERE WERE (5) FIVE WOMEN RESIDING IN THE FACILITY ALONG WITH THE (2) TWO DIRECT CARE STAFF. ON 2/26/07 DURING ENTRANCE CONFERENCE WITH THE CO-OWNER, HE STATED THAT THE TWO ADDITIONAL PEOPLE ARE FAMILY MEMBERS WHO RESIDE THERE. ON 2/28/07 AT 11:35AM DURING THE EXIT CONFERENCE, IT WAS MENTIONED TO THE ADMINISTRATOR THAT "AUNTS" ARE NOT CONSIDERED TO BE QUALIFYING RELATIVES PER REGULATION DEFINITIONS. THE ADMINISTRATOR ACKNOWLEDGED THE PROBLEM AND STATED SHE WOULD BEGIN MEASURES TO COME INTO COMPLIANCE.	A13	Having misunderstood the Regulations regarding Relatives, WE mistakingly allowed 2 family members to move in (2 aunties) WE have been informed of the correct terms identifying qualified Relatives. WE will insure that in the future WE will not make the same mistake again. Correction action has been taken regarding both aunts. They were moved out on 3-30-7 and 4-30-7	

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A17	Continued From page 2	A17		
A17	7 NMAC 8.2.17 PERSONNEL 7.8.2.17 PERSONNEL: The adult residential care facility must have and implement written personnel policies. The personnel policies must address the following: A. Qualifications for all professional and non-professional disciplines. B. Staff conduct which must foster resident safety and well-being and must not be detrimental to resident care. C. Staff training, appropriate to staff responsibilities, including, at a minimum, an orientation and an on-going, but at least annual, program which includes: Fire Safety, First Aid, Safe Food Handling practices, Confidentiality of Records and Resident information, Infection Control, Resident Rights, Reporting Requirements for Abuse, Neglect, and Exploitation, Transportation Safety for Assisting residents and operating vehicles to transport residents and Providing Quality Resident Care based on current resident needs. D. Employee personnel records, including an application for employment, TB tests and certificates, training records, and personnel actions. [4-7-97; 7.8.2.17 NMAC - Rn & A, 7 NMAC 8.2.17, 8-31-00] This REQUIREMENT is not met as evidenced by: BASED ON RECORD REVIEW AND STAFF INTERVIEW, THE FACILITY FAILED TO HAVE AN ONGOING PROGRAM OF EMPLOYEE TRAINING FOR 100% OF FACILITY EMPLOYEES. THE FINDINGS ARE: ON 2/27/07, DURING REVIEW OF THE	A17		

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A17	Continued From page 3 FACILITY RECORDS, IT WAS NOTED THAT THERE WAS NO EVIDENCE OF: CURRENT FIRST AID AND CPR TRAINING, INFECTION CONTROL, CONFIDENTIALITY AND RESIDENT'S RIGHTS TRAINING FOR 2 DIRECT CARE STAFF. ON 2/28/07, 11:35AM DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR, SHE CONFIRMED THE PROBLEM AND STATED THAT TRAINING IN THESE AREAS WOULD OCCUR.	A17	This will be corrected by holding training either in facility or at other location, annually at the least, for infection control, confidentiality & residents Rights and first aid & CPR for 2 of 2 direct care staff this will be completed by: 5-7-07	
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.	A19		

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A19	Continued From page 4 (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. (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.	A19		

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A19	Continued From page 5 (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 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: REFER TO 7.8.2.19(C)(1)(a-f)	A19		

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A19	Continued From page 6 BASED ON RECORD REVIEW AND INTERVIEW, THE FACILITY FAILED TO CONVENE A TEAM MEETING, TO ENSURE THAT THE FACILITY CAN MEET THE HIGH ACUITY HEALTHCARE NEEDS FOR 1 OF 3 RESIDENTS, (#1) REQUIRING NURSING SERVICES. THE FINDINGS ARE: DURING REVIEW OF THE RESIDENT RECORDS, THERE WAS NO DOCUMENTATION THAT A TEAM MEETING WAS HELD FOR RESIDENT #1 WHO RESIDED AT THE FACILITY AND WAS CURRENTLY RECEIVING THE SERVICES OF A HOSPICE NURSING AGENCY. ON 2/28/07 AT 11:35AM,DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR , SHE ACKNOWLEDGED THE PROBLEM. REFER TO 7.8.2.19(C)(1)(d) BASED ON RECORD REVIEW AND INTERVIEW, THE FACILITY FAILED ENSURE THAT THE NEW MEXICO STATE OMBUDSMAN WAS PART OF THE TEAM MEETING TO DETERMINE APPROPRIATENESS OF PLACEMENT FOR AN ADMISSION/RETENTION EXCEPTION, REQUIRING NURSING SERVICES FOR 1 OF 3 RESIDENTS (#1). THE FINDINGS ARE: DURING REVIEW OF THE RESIDENT RECORDS, THERE WAS NO DOCUMENTATION THAT AN INTERDISCIPLINARY TEAM MEETING WAS HELD FOR RESIDENT #1 RESIDING IN THE FACILITY AND WHO WAS CURRENTLY	A19	In the future a team meeting will be held and documentation will be kept of meeting Prior to resident being signed on to hospice. Resident #1 has since graduated from hospice & is no longer receiving their services Change were made immediatly to our policy 3-1-07 In the future the NM State ombudsman will be part of a team meeting TO determine appropriateness of admission Requires nursing services for any Resident Continued	

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A19	Continued From page 7 RECEIVING THE SERVICES OF A HOSPICE NURSING AGENCY. ON 2/28/07, 11:35AM DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR, SHE ACKNOWLEDGED THE PROBLEM. REFER TO 7.8.2.19(C)(2)(a) BASED ON RECORD REVIEW AND INTERVIEW, THE FACILITY FAILED TO MAINTAIN DOCUMENTATION OF AN INDIVIDUAL SERVICE PLAN (ISP) (DEVELOPED BY THE INTERDISCIPLINARY TEAM) IDENTIFYING THE RESIDENT'S SPECIFIC NEEDS AND ADDRESSING THE MANNER IN WHICH SUCH NEEDS WILL BE MET BY THE HOSPICE AGENCY AND THE FACILITY FOR 1 OF 3 RESIDENTS (RESIDENT #1). THE FINDINGS ARE: DURING REVIEW OF THE RESIDENT RECORDS, THERE WAS NO DOCUMENTATION OF AN INDIVIDUAL SERVICE PLAN FOR RESIDENT #1 WHO RESIDED AT THE FACILITY AND WAS CURRENTLY RECEIVING THE SERVICES OF A HOSPICE NURSING AGENCY. ON 2/28/07, 11:35AM DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR, SHE ACKNOWLEDGED THE PROBLEM. REFER TO 7.8.2.19(C)(2)(b) BASED ON RECORD REVIEW AND INTERVIEW, THE FACILITY FAILED TO ENSURE THAT FIRE SAFETY EVACUATION	A19	and documentation will be kept of said meeting. this policy is in effect immediately said resident is no longer hospice 3-1-07 active care plan has been received on said resident and is in resident file- Resident has since graduated from hospice - in the future an individual service plan will be developed by interdisciplinary team prior to any resident receiving hospice care & said plan will be kept on file This policy effective 3-1-07	

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A19	Continued From page 8 RATINGS (FSES) FOR RESIDENTS AND RESULTANT EVACUATION SCORE FOR THE FACILITY WAS DONE FOR 1 OF 3 RESIDENTS (#1) RECEIVING SERVICES FROM A HOSPICE NURSING AGENCY. THE FINDINGS ARE: A. DURING REVIEW OF THE FACILITY RECORDS, IT WAS NOTED THAT NO FSES WAS ON FILE FOR RESIDENT #1. THE TOTAL FACILITY EVACUATION SCORE WAS ALSO UNAVAILABLE. B. ON 2/28/07 AT 11:35AM DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR , SHE STATED THAT SHE WOULD CORRECT THE PROBLEM. REFER TO 7.8.2.19(C)(3) BASED ON RECORD REVIEW AND INTERVIEW, THE FACILITY FAILED TO NOTIFY THE LICENSING AUTHORITY WITHIN FIVE (5) DAYS OF THE COMPLETION OF AN ADMISSION/RETENTION EXCEPTION, REQUIRING NURSING SERVICES FOR 1 OF 6 RESIDENTS (#1). THE FINDINGS ARE: DURING REVIEW OF THE RESIDENT RECORDS, THERE WAS NO DOCUMENTATION THAT THE LICENSING AUTHORITY HAD BEEN NOTIFIED OF AN ADMISSION RETENTION/EXCEPTION MEETING FOR RESIDENT #1. ON 2/28/07, 11:35AM DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR , SHE ACKNOWLEDGED THE PROBLEM.	A19	starting immediately the licensing authority will be notified within 5 days of completion of an admission/ retention exception Requiring nursing services. this plan will be documented & kept in resident file. 3-07	

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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: REFER TO NMAC 7.8.2.24 BASED ON OBSERVATION, RECORD REVIEW AND INTERVIEW, THE FACILITY FAILED TO MAINTAIN CURRENT VACCINATIONS FOR VARIOUS FACILITY PETS. THE FINDINGS ARE: DURING A TOUR OF THE FACILITY AND THROUGHOUT THE COURSE OF THE SURVEY, THE FOLLOWING PETS WERE SEEN INSIDE THE FACILITY: -WHITE POODLE -2 CATS REVIEW OF THE FACILITY RECORDS YIELDED NO CURRENT VACCINATIONS FOR THE FACILITY PETS. ON 2/28/07 AT 11:35AM DURING AN EXIT INTERVIEW WITH THE ADMINISTRATOR, SHE STATED THAT THE VACCINATIONS FOR THE PETS WOULD BE KEPT CURRENT IN THE FUTURE.	A24	All pets (cats + dogs) have received proper Vaccination + paper work is on file; we will monitor this annually + vaccinate as necessary This was Corrected on 2-28-07	

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A27	Continued From page 10	A27		
A27	7 NMAC 8.2.27 INDIVIDUAL SERVICE PLAN 7.8.2.27 INDIVIDUAL SERVICE PLAN: A. An individual service plan, if prompted by the resident assessment, shall be developed and implemented within fourteen (14) days of admission, and must address those areas of need as identified in the resident assessment. The individual service plan must be reviewed by a licensed nurse at least every six (6) months, and revised as needed at the time of each assessment and consistently implemented in response to the resident's needs. B. The individual service plan must include the following: (1) Description of identified needs as noted in the resident assessment. (2) Written description of what services will 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) Goal and outcome of the service. (8) Documentation of the facility's determination that it is able to meet the needs of the resident.. [7-11-86, 1-11-90, 4-7-97; 7.8.2.27 NMAC - Rn, 7 NMAC.8.2.27, 8-31-00] This REQUIREMENT is not met as evidenced by: REFER TO 7.8.2.27(A-B) INDIVIDUAL SERVICE PLAN BASED ON RECORD REVIEW AND INTERVIEW, THE FACILITY FAILED TO MAINTAIN DOCUMENTATION OF AN INDIVIDUALIZED SERVICE PLAN (ISP), DEVELOPED BY THE INTERDISCIPLINARY,	A27		

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A27	Continued From page 11 TEAM IDENTIFYING THE RESIDENT'S SPECIFIC NEEDS AND ADDRESSING THE MANNER IN WHICH SUCH NEEDS WILL BE MET BY HOSPICE AND BY THE FACILITY FOR 1 OF 3 RESIDENTS (#1). THE FINDINGS ARE: DURING REVIEW OF THE RESIDENT RECORDS, THERE WAS NO DOCUMENTATION THAT AN COORDINATED INDIVIDUALIZED SERVICE PLAN WAS ON FILE FOR RESIDENT #1 WHO RESIDED AT THE FACILITY AND WAS CURRENTLY RECEIVING THE SERVICES OF A HOSPICE NURSING AGENCY. ON 2/28/07 AT 11:35AM DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR, SHE ACKNOWLEDGED THE PROBLEM AND STATED THAT THE PROBLEM COULD BE CORRECTED.	A27	In the future there will be records kept of documentation Individualized Services plan on file for any Resident whose resident assessment has prompted such action. Said resident is no longer receiving hospice services 3-07	
A32	7 NMAC 8.2.32 HANDLING OF EMERGENCIES 7.8.2.32 HANDLING OF EMERGENCIES: A. Each resident or resident representative shall designate upon admission, a physician to be called in case of medical necessity. Each resident or representative may also designate a concerned person to be called in case of an emergency. The facility shall establish a policy to secure medical assistance if the resident's own physician is not available. In the event of an illness or an injury to the resident, an appropriately licensed health professional must be notified by the facility. B. The facility must have available, a first aid kit containing gauze, tape, adhesive, antiseptic, and bandages for emergencies. The first aid kit must be kept in a designated, easily accessible place within the facility.	A32		

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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
A32	Continued From page 12 C. An easily accessible and functional telephone for summoning help in case of an emergency must be available in each facility. A pay telephone will not fulfill this requirement. D. A list of emergency numbers, including, but not limited to, Fire Department, Police Department, Ambulance Services, Poison Control, Licensing and Certification, Adult Protective Services, and Ombudsman must be posted near each public telephone in the facility. [7-1-64, 9-15-70, 5-26-72, 7-19-75, 9-24-76, 7-11-86, 1-1-90, 4-7-97; 8.2.32 NMAC - Rn, 7 NMAC 8.2.32, 8-31-00] This REQUIREMENT is not met as evidenced by: REFER TO 7.8.2.32(D) HANDLING OF EMERGENCIES BASED ON OBSERVATION AND INTERVIEW, THE FACILITY FAILED TO ENSURE THAT ALL REQUIRED EMERGENCY PHONE NUMBERS WERE LISTED ON THE EMERGENCY CONTACT LIST. THE FINDINGS ARE: ON 2/28/07 AT DURING A TOUR OF THE FACILITY, IT WAS NOTED THAT THE PHONE NUMBER TO THE HEALTH FACILITY LICENSING AND CERTIFICATION BUREAU WAS NOT LISTED ON THE FACILITY EMERGENCY CONTACT LIST. ON 2/28/07 AT 11:35AM DURING EXIT INTERVIEW WITH THE ADMINISTRATOR, SHE STATED THAT SHE WOULD ADD THE PHONE NUMBER TO THE EMERGENCY LIST OF CONTACTS.	A32	This number has been added to the emergency contacts list and will be displayed from this day forward 2-28-07	
A34	7 NMAC 8.2.34 RESIDENT RIGHTS 7.8.2.34 RESIDENT RIGHTS: All licensed	A34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5827	A. BUILDING _____ B. WING _____	02/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHED BY A WHITE DOVE ASSISTED LIVIN	1605 CARDENAS DRIVE NE ALBUQUERQUE, NM 87110

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A34	Continued From page 13 facilities shall be aware of, protect, and enhance the rights of all residents. A. Prior to admission to a facility, a resident and/or legal representative shall be given a written description of the legal rights of the residents translated into another language, if necessary, to meet the residents understanding. B. If the resident is incapable of understanding his/her legal rights, and if he/she has no legal representative, then the licensee shall also give a written copy of the resident's legal rights to one of the following persons, in this order of priority: (1) the resident's spouse; (2) any of the resident's adult children; (3) either of the resident's parents; (4) any relative the resident has lived with for six or more months before admission; (5) a person who has been caring for, or paying benefits on behalf of the resident; (6) a placing agency; or (7) any other person, e.g., Ombudsman. C. These resident rights and the telephone number for the Ombudsman Program shall be posted in a conspicuous place in the facility: D. The facility, to protect resident rights must: (1) Treat all residents with courtesy, respect, dignity and compassion. (2) To the extent that resident required services fall within the scope of the facilities program, avoid discrimination in admission or services because of a resident's age, race, religion, physical or mental disability, or nationality. (3) Furnish residents written information about all services provided by the facility and their costs, and advance written notice of any changes. (4) Assure that residents have a safe	A34		

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A34	Continued From page 14 and sanitary living environment. (5) Provide humane care. (6) Assure the resident's rights to privacy in medical care, including privacy during medical examinations, consultations and treatment; and protect the confidentiality of the resident medical records. (7) Protect and assure the resident's 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. (8) Assure the resident's right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and assure the resident's right's to receive visits from family, friends, lawyers, ombudsmen and community organizations. (9) Prohibit the use of any and all physical and chemical restraints. (10) Assure the residents are free from physical and emotional abuse and neglect. (11) Assure that all residents are free from financial abuse and exploitation by facility staff and/or management. (12) Consistent with the resident's health, abilities and security, assure the right of the resident to freely participate in religious, social, community and other activities; and freely associate with persons in and out of the facility. (13) Permit the residents to leave the facility freely and return without unreasonable restriction. (14) Prevent unjustified room transfers or discharge from this facility. (15) Use care and management practices that foster social interaction and avoid practices that unnecessarily result in social isolation.	A34		

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A34	Continued From page 15 (16) Provide services consistent with informed consent. (17) Assure that all residents may voice grievances to the facility staff, public officials, the ombudsmen or any other person, without fear of reprisal or retaliation. (18) Promptly address and resolve resident complaints. (19) Foster resident participation and understanding in the development, review and modification of the resident's plan for care and treatment. (20) Respect a resident's choice of doctor, pharmacist and other health care provider. (21) Respect a resident's medical treatment decisions and advance directives, such as living wills and durable powers of attorney for health care. (22) Respect a resident's right to keep and use personal possessions without loss or damage. (23) Allow each resident to manage and control the resident's personal finances to the extent that the resident is able, and provide to every resident a written record of all financial arrangements and transactions involving that resident's funds. (24) Allow residents to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management. (25) Require no resident to work for the facility. (26) Consult with the incapacitated resident regarding his/her care, regardless of the involvement of a guardian or surrogate decision maker. (27) Assure the involvement in, and consent of, an incapacitated resident's guardian	A34		

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A34	Continued From page 16 or surrogate decision maker in the resident's care. E. The resident's rights shall not be restricted unless the resident agrees to such a restriction, and unless this restriction is described in detail in his/her individual service plan. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.34 NMAC - Rn, 7 NMAC 8.2.34, 8-31-00] This REQUIREMENT is not met as evidenced by: REFER TO 7.8.2.34 BASED ON OBSERVATION AND INTERVIEW, THE FACILITY FAILED TO PROCURE PHYSICIAN'S ORDERS FOR THE USE OF BED RAILS FOR 1 of 3 FACILITY RESIDENTS (#3). THE FINDINGS ARE: ON 2/26/07 AT 11:00AM DURING A TOUR OF THE FACILITY, IT WAS NOTED THAT THE BED RAILS FOR RESIDENT #3, WERE IN THE UP POSITION AND AVAILABLE ON THIS RESIDENT'S "HOSPITAL TYPE" BED. ON 2/28/07AT 11:35AM DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR, SHE STATED THAT THE BED RAILS WERE AVAILABLE FOR THE PURPOSE OF RESIDENT MOBILITY. THE ADMINISTRATOR ACKNOWLEDGED THAT THERE WAS NO PHYSICIAN'S ORDER INDICATING THE USE OF ANY SIZE BED RAILS FOR THE RESIDENT.	A34	In the future any resident who requires bed rails for mobility will not have rails installed until proper physicians orders are received Proper orders for said resident's bed rails were received on 3-20-07 and are in Resident file This was completion 3-20-07	
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	A35		

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A35	Continued From page 17 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 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	A35		

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A35	Continued From page 18 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 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: REFER TO 7.8.2.35 (A)(1) BASED ON OBSERVATION AND INTERVIEW, THE FACILITY FAILED TO ENSURE THAT NARCOTIC CLASS MEDICATIONS WERE STORED UNDER LOCKED CONDITIONS. THE FINDINGS ARE: A. ON 2/26/07 AT 11:10AM DURING A TOUR	A35		

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A35	Continued From page 19 OF THE FACILITY KITCHEN, IT WAS NOTED THAT THE MORPHINE SULFATE PRESCRIBED FOR A FAMILY MEMBER OF THE ADMINISTRATOR'S WAS STORED IN THE FACILITY REFRIGERATOR OUTSIDE OF A LOCKED BOX. B. ON 2/28/07 AT 11:35AM DURING EXIT INTERVIEW, THE ADMINISTRATOR CONFIRMED THAT THE MEDICATION HAD NOT BEEN STORED APPROPRIATELY AND STATED THAT SHE HAD FIXED THE PROBLEM. REFER TO 7.8.2.35 (A)(7) BASED ON OBSERVATION AND INTERVIEW, THE FACILITY FAILED TO ENSURE FREE STANDING OXYGEN TANKS WERE PROPERLY STORED ACCORDING TO THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 99. THE FINDINGS ARE: NFPA 99-64 REGULATIONS READ AS FOLLOWS: "4-5.1.1.1 CYLINDERS IN SERVICE AND IN STORAGE SHALL BE INDIVIDUALLY SECURED AND LOCATED TO PREVENT FALLING OR BEING KNOCKED OVER." ON 2/26/07 AT 11:00AM DURING A TOUR OF THE FACILITY, SEVERAL FREE STANDING OXYGEN CYLINDERS WERE LOCATED INSIDE IN THE ENTRY WAY TO THE HOME WHILE OTHERS WERE STORED "IN STRIKING RANGE" OF THE MOVING DOOR. ALL WERE STANDING UPRIGHT AND NOT INDIVIDUALLY SECURED.	A35	TO correct this situation a key lock was Purchased for storage box in refrigerator and will remain on box from this day forward corrective action completed 2-27-07 This situation was corrected by Placing oxygen cylinders flat on ground to make it impossible to	

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A35	Continued From page 20 ON 2/28/07, AT 11:35AM DURING THE EXIT CONFERENCE, THE ADMINISTRATOR ACKNOWLEDGED THE PROBLEM. \ REFER TO 7.8.2.35 (B)(1) BASED ON RECORD REVIEW THE FACILITY FAILED TO HAVE AT LEAST QUARTERLY REVIEWS BY THE CONSULTANT PHARMACIST. THE FINDINGS ARE: DURING REVIEW OF THE FACILITY RECORDS, IT WAS NOTED THAT THE CONSULTANT PHARMACIST VISITED THE FACILITY ON 1/26/06 BUT DID NOT VISIT AGAIN UNTIL 5/24/06. REFER TO 7.8.2.35 (B)(1) BASED ON RECORD REVIEW, THE FACILITY FAILED TO CORRECT DOCUMENTATION ISSUES AS RECOMMENDED BY THE CONSULTANT PHARMACIST. THE FINDINGS ARE: DURING REVIEW OF THE CONSULTANT PHARMACIST VISIT FORMS FOR 2006, THE PHARMACIST NOTED IN 3 OF THOSE 4 VISITS THAT THE MEDICATION ADMINISTRATION RECORD (MAR) WAS NOT "SIGNED" AS IT SHOULD BE AFTER THE ADMINISTRATION OF MEDICATIONS. DURING REVIEW OF THE MAR FOR February 2007, THE FOLLOWING WAS NOTED: 1. RESIDENT #1'S MAR HAD A TOTAL OF 34 BLANK SPACES FROM February 23-27	A35	knock cylinders over. They were placed in an area where they are out of the way + no cylenders, in the future will be placed upright unless security Corrected 2-28-07 Corrective action will be taken immediately by calling said consultant pharmacist in advanced of quarterly visits to ensure visits take place 3-07 Corrective action has been taken to ensure proper Initials and signature are written immediately after each resident receives there medication on nightly reviews	

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A35	Continued From page 21 WHERE NO DOCUMENTATION EXISTED AS TO WHETHER THE RESIDENT HAD RECEIVED MEDICATIONS AS PRESCRIBED. 2. RESIDENT #2'S MAR HAD A TOTAL OF 33 BLANK SPACES FROM February 23-27 WHERE NO DOCUMENTATION EXISTED AS TO WHETHER THE RESIDENT HAD RECEIVED MEDICATIONS AS PRESCRIBED. 3. RESIDENT #3'S HAD A TOTAL OF 28 BLANK SPACES FROM February 23-27 WHERE NO DOCUMENTATION EXISTED AS TO WHETHER THE RESIDENT HAD RECEIVED MEDICATIONS AS PRESCRIBED.	A35	of mars will be done to ensure proper documentation. Corrective action has been taken to ensure proper initials & signatures are written immediately after each resident receives meals. A nightly review of documentation will be done to ensure proper documentation 3-07	
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 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	A36		

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A36	Continued From page 22 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. 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:	A36		

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A36	Continued From page 23 (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: REFER TO 7.8.2.36(F)(8) BASED ON RECORD REVIEW, THE FACILITY FAILED TO ENSURE THAT MEDICATION ADMINISTRATIONS WERE DOCUMENTED WITH STAFF INITIALS. THE FINDINGS ARE: DURING REVIEW OF THE CONSULTANT PHARMACIST VISIT FORMS FOR 2006, THE PHARMACIST NOTED IN 3 OF THOSE 4 VISITS THAT THE MEDICATION ADMINISTRATION RECORD (MAR) WAS NOT "SIGNED" AS IT SHOULD BE AFTER ADMINISTRATION OF MEDICATIONS. DURING REVIEW OF THE MAR FOR February 2007, THE FOLLOWING WAS NOTED: 1. RESIDENT #1'S MAR HAD A TOTAL OF 34 BLANK SPACES FROM February 23-27 WHERE NO DOCUMENTATION EXISTED AS	A36	Corrective action has been taken to ensure proper initials immediately after each resident receives medications & a nightly review of documentation will be done to ensure proper documentations 3-07	

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A36	Continued From page 24 TO WHETHER THE RESIDENT HAD RECEIVED MEDICATIONS AS PRESCRIBED. 2. RESIDENT #2'S MAR HAD A TOTAL OF 33 BLANK SPACES FROM February 23-27 WHERE NO DOCUMENTATION EXISTED AS TO WHETHER THE RESIDENT HAD RECEIVED MEDICATIONS AS PRESCRIBED. 3. RESIDENT #3'S HAD A TOTAL OF 28 BLANK SPACES FROM February 23-27 WHERE NO DOCUMENTATION EXISTED AS TO WHETHER THE RESIDENT HAD RECEIVED MEDICATIONS AS PRESCRIBED.	A36	Previously stated corrective action has been taken to ensure proper initials & signature are written after each resident receives meds a nightly review will be done to ensure proper documentation 3-07	
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 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	A41		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5827	A. BUILDING _____ B. WING _____	02/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHED BY A WHITE DOVE ASSISTED LIVIN	1605 CARDENAS DRIVE NE ALBUQUERQUE, NM 87110

(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 with NFPA 101, Fire Safety Equivalency System (FSES), 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 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	A41		

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	5827	A. BUILDING _____ B. WING _____	02/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHED BY A WHITE DOVE ASSISTED LIVI	1605 CARDENAS DRIVE NE ALBUQUERQUE, NM 87110

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A41	Continued From page 26 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 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.	A41		

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	5827	A. BUILDING _____ B. WING _____	02/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHED BY A WHITE DOVE ASSISTED LIVIN	1605 CARDENAS DRIVE NE ALBUQUERQUE, NM 87110

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A41	Continued From page 27 (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: Refer to NMAC 7.8.2.14(A)(2) BASED ON RECORD REVIEW AND INTERVIEW, THE FACILITY FAILED TO ENSURE THAT FIRE SAFETY EVACUATION RATINGS (FSES) FOR RESIDENTS AND RESULTANT EVACUATION SCORE FOR THE FACILITY WAS DONE FOR THREE OF THREE SAMPLED RESIDENTS (#1, 2 AND 3). THE FINDINGS ARE: DURING REVIEW OF THE FACILITY RECORDS, IT WAS NOTED THAT NO FSES WERE ON FILE FOR RESIDENT #1, 2 AND 3. THE TOTAL FACILITY EVACUATION SCORE	A41	Corrective action has been taken to ensure all residents have ~~been~~ fire safety eval. rating and entire future Residents will have a rating within one ~~week~~ of arrival the resultant eval-uation score	

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	5827	A. BUILDING _____ B. WING _____	02/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHED BY A WHITE DOVE ASSISTED LIVIN	1605 CARDENAS DRIVE NE ALBUQUERQUE, NM 87110

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A41	Continued From page 28 WAS ALSO UNAVAILABLE. ON 2/28/07, AT 11:35AM DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR, SHE STATED THAT SHE WOULD CORRECT THE PROBLEM.	A41	for the facility has been completed & all paper work is on file 3-07	
A43	7 NMAC 8.2.43 MAINTENANCE OF BUILDING AND GROUNDS 7.8.2.43 MAINTENANCE OF BUILDING AND GROUNDS: The building(s) must be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following: A. All electrical, fire protection signaling, mechanical, telephone, water supply, heating, fire protection, and sewage disposal systems maintained in a safe and functioning condition, including regular inspections of these systems, (as applicable). B. The building, furniture and furnishings, storage areas, and grounds of the facility must be maintained in a safe, sanitary, and presentable condition at all times. C. Storage areas must be kept free from accumulation of refuse, discarded furniture, old newspapers, that create a fire hazard. D. Floors shall be maintained stable, firm, slip-resistant and free of tripping hazards. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.43 NMAC - Rn, 7 NMAC 8.2.43, 8-31-00] This REQUIREMENT is not met as evidenced by: REFER TO 7.8.2.43(B) BASED ON OBSERVATION AND INTERVIEW, THE FACILITY FAILED TO ENSURE THAT THE CAULKING WAS INTACT IN THE FACILITY BATHROOM. THE FINDINGS ARE: ON 2/26/07 AT 11:00AM DURING A TOUR OF	A43		

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	5827	A. BUILDING _____ B. WING _____	02/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHED BY A WHITE DOVE ASSISTED LIVI	1605 CARDENAS DRIVE NE ALBUQUERQUE, NM 87110

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A43	Continued From page 29 THE FACILITY, IT WAS NOTED THAT THE BATHROOM CAULKING WAS PULLING AWAY FROM THE WALL. ON 2/28/07 AT 11:35AM DURING THE EXIT INTERVIEW, THE CO-OWNER ACKNOWLEDGED THE PROBLEM. REFER TO 7.8.2.43(D) BASED ON OBSERVATION AND INTERVIEW, THE FACILITY FAILED TO ENSURE THAT THE FACILITY FLOORING WAS MAINTAINED IN A STABLE AND TRIP-FREE MANNER FOR 2 OF 3 FACILITY RESIDENTS. THE FINDINGS ARE: ON 2/26/07 AT 11:05AM DURING A TOUR OF THE FACILITY IT WAS NOTED THAT 2 OF 3 FACILITY RESIDENTS WERE AMBULATORY. ON 2/26/07 AT 11:10AM DURING A TOUR OF THE FACILITY, IT WAS NOTED THAT THE LINOLEUM IN THE KITCHEN WAS PULLING UP BETWEEN THE KITCHEN AND THE OFFICE AREA. ON 2/28/07 AT 11:35AM DURING THE EXIT INTERVIEW, THE ADMINISTRATOR ACKNOWLEDGED THE PROBLEM.	A43	new caulking has been applied where appropriate. and this will be monitored in the future & repaired according ly 3-1-07 This problem has been permately fixed by placing a piece of wood (½ of a doweas) between kitchen & office securing it to the floor on top of linoleum 3-1-07	
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	A45		

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A45	Continued From page 30 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. 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,	A45		

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A45	Continued From page 31 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: REFER TO 7.8.2.45(A) BASED ON RECORD REVIEW AND INTERVIEW, THE FACILITY FAILED TO HAVE ON SITE, DOCUMENTATION OF A FUEL FIRE HEATING SYSTEM INSPECTION. THE FINDINGS ARE: ON 2/26/07 DURING REVIEW OF THE ADMINISTRATIVE FILES, NO DOCUMENTATION OF A FUEL FIRE INSPECTION CONDUCTED WITHIN THE LAST YEAR WAS FOUND. ON 2/28/07 AT 11:35AM DURING EXIT INTERVIEW, THE ADMINISTRATOR STATED THAT THESE INSPECTIONS WOULD BE DONE ANNUALLY IN THE FUTURE. REFER TO 7.8.2.45(G) BASED ON OBSERVATION AND INTERVIEW, THE FACILITY FAILED TO PROPERLY MAINTAIN WINDOW SCREENS IN 1 OF 3 RESIDENT ROOMS. THE FINDINGS ARE: ON 2/26/07 AT 11:00AM DURING A TOUR OF THE FACILITY, IT WAS NOTED THAT (2) WINDOW SCREENS WERE EITHER MISSING OR HAD HOLES IN IT. ON 2/28/07, AT 11:35AM DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR, SHE ACKNOWLEDGED THE PROBLEM.	A45	This was corrected by having an inspection done on 2-28-07 and will be done annually. Receipt of inspection is on file This program has been corrected by replacing screens with new ones - this shall be monitored by physically checking while in resident ROOM	2-28-07 3-07

Division of Health Improvement

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A46	7 NMAC 8.2.46 WATER 7.8.2.46 WATER: A. A facility must be provided with an adequate supply of water which is of a safe and sanitary quality suitable for domestic use. Hot and cold running water under pressure must be distributed to all food preparation areas, lavatories, washrooms, and laundries. B. If the water supply is not obtained from an approved public system, the private water system must be inspected, tested, and approved by the Environmental Health Authority prior to licensure. It is the facility's responsibility to insure that subsequent periodic testing or inspection of such private water systems be made at intervals as prescribed by the Environmental Authority. C. The hot water temperature accessible to residents must be maintained at a minimum of 95 degrees Fahrenheit and a maximum of 110 degrees Fahrenheit. Hot water in excess of 110 degrees Fahrenheit is permitted in kitchen and laundry areas, provided residents are supervised to prevent injury. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.46 NMAC - Rn, 7 NMAC 8.2.46, 8-31-00] This REQUIREMENT is not met as evidenced by: REFER TO 7.8.2.46(A) BASED ON OBSERVATION AND INTERVIEW, THE FACILITY FAILED TO ENSURE THAT A RESIDENT WITH A PRIVATE BATHROOM HAD ADEQUATE HOT AND COLD RUNNING WATER COMING OUT OF THE TAP. THE FINDINGS ARE: ON 2/26/07 AT 11:00AM DURING A TOUR OF THE FACILITY, IT WAS NOTED THAT A SMALL TRICKLE OF WATER WAS COMING OUT OF SINK IN RESIDENT #1'S PRIVATE ROOM.	A46	This problem will be identified by checking once a week for evidence of blockage on screen in faucet and corrected by cleaning screen once a month cleared 2-28-07	

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A46	Continued From page 33 ON 2/28/07 AT 11:35AM DURING THE EXIT CONFERENCE, THE ADMINISTRATORS ACKNOWLEDGED THE PROBLEM.	A46		
A49	7 NMAC 8.2.49 ELEMENTS OF FACILITY ELECTRICAL SYSTEM 7.8.2.49 ELEMENTS OF FACILITY ELECTRICAL SYSTEM: A. All fuse and breaker boxes must be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility must know the location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances must be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear. (2) Extension cords are prohibited. EXCEPTION: The use of a multi-socket United Laboratories approved (U/L APPROVED) surge protector with integrated circuit breaker no greater than six (6) foot in length is permitted. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.49 NMAC - Rn, 7 NMAC 8.2.48, 8-31-00] K This REQUIREMENT is not met as evidenced by: REFER TO 7.8.2.49(A) BASED ON OBSERVATION AND INTERVIEW, THE FACILITY FAILED TO ENSURE THAT ALL FUSES WERE LABELLED TO INDICATE THE AREA OF SERVICE. THE FINDINGS ARE:	A49		

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A49	Continued From page 34 ON 2/28/07 AT 9:55AM DURING A TOUR OF THE FACILITY, IT WAS NOTED THAT FUSE #3 WAS UNLABELLED. ON 2/28/07 AT 9:56AM DURING INTERVIEW WITH THE CO-OWNER, HE STATED THAT HE WAS UNSURE WHAT THE BREAKER SERVICED AT THE TIME OF THE INTERVIEW.	A49	fuse #3 has been identified & labeled according by 2-28-07	
A60	7 NMAC 8.2.60 FIRE ALARMS, SMOKE DETECTORS, AND OTHER EQUIP 7.8.2.60 FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: A. FIRE ALARM SYSTEM: A manual fire alarm system shall be provided. The manual fire alarm must be inspected and approved in writing by the fire authority having jurisdiction. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have a fire alarm system. B. SMOKE AND HEAT DETECTION: Approved smoke detectors shall be installed on each floor to provide when activated an alarm which is audible in all sleeping areas. Areas of assembly such as the dining and living room must also be provided with smoke detectors. (1) Detectors shall be powered by the house electrical service and have battery back up. (2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room. (3) Smoke detectors must be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all enclosed kitchens and also powered by the house electrical service.	A60		

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A60	Continued From page 35 [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.60 NMAC - Rn, 7 NMAC 8.2.60, 8-31-00] This REQUIREMENT is not met as evidenced by: REFER TO NMAC 7.8.2.60(B) BASED ON OBSERVATION AND INTERVIEW, THE FACILITY FAILED TO ENSURE THAT THE SMOKE DETECTORS WERE OPERATIONAL. THE FINDINGS ARE: ON 2/26/07 AT 11:00AM DURING A TOUR OF THE FACILITY, IT WAS NOTED THAT TWO OF THE FACILITY SMOKE DETECTORS DID NOT FUNCTION DUE TO "DEAD" BATTERIES. ON 2/28/07 AT 11:35AM DURING THE EXIT CONFERENCE, THE ADMINISTRATORS ACKNOWLEDGED THE PROBLEM.	A60	This will be corrected by changing batteries in smoke detectors. once a month we will test all smoke detectors units Batteries were replaced on all units 2-28-07	
A66	7 NMAC 8.2.66 RELATED REGULATIONS AND CODES 7.8.2.66 RELATED REGULATIONS AND CODES: Adult residential care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96). B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96). C. Adjudicatory Hearings, New Mexico Department of Health, 7 NMAC 1.2 (2-1-96). [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.66 NMAC - Rn, 7 NMAC 8.2.66, 8-31-00] This REQUIREMENT is not met as evidenced by: REFER TO NMAC 7.1.12.8(D) - PROVIDER	A66		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHED BY A WHITE DOVE ASSISTED LIVIN	1605 CARDENAS DRIVE NE ALBUQUERQUE, NM 87110

(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
A66	Continued From page 36 REQUIREMENT TO DOCUMENT INQUIRY TO REGISTRY BASED ON RECORD REVIEW AND INTERVIEW, THE FACILITY FAILED TO MAINTAIN DOCUMENTATION THAT THE EMPLOYEE ABUSE REGISTRY (EAR) DATABASE WAS CHECKED IN ACCORDANCE WITH NMAC 7.1.12 (EFFECTIVE January 1, 2006) FOR 2 OF 2 STAFF (E1 AND E2.). THE FINDINGS ARE: DURING REVIEW OF THE EMPLOYEE FILES, IT WAS NOTED THAT BOTH ADMINISTRATORS (E1 AND E2) DID NOT HAVE, ON FILE, DOCUMENTATION OF SEARCH ON THE REGISTRY USING THE INDIVIDUAL'S IDENTIFYING INFORMATION. ON 2/28/07 AT 11:35AM DURING EXIT INTERVIEW WITH THE ADMINISTRATOR, SHE ACKNOWLEDGED THAT THIS WAS NOT YET DONE. REFER TO 7.1.13.10(C1) - TRAINING CURRICULUM REQUIREMENTS FOR INCIDENTS, ABUSE, NEGLECT AND EXPLOITATION BASED ON RECORD REVIEW AND INTERVIEW, THE FACILITY FAILED TO ENSURE A CURRICULUM FOR TRAINING ON ABUSE, NEGLECT AND MISAPPROPRIATION OF PROPERTY WAS IN PLACE AS SET FORTH IN THE INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING	A66	will be corrected by running said employees through the Cov-EAR any potential employees will be cleared through system before been employed corrective action was completed 4-23-07 (said documentation is in administrators files)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5827	A. BUILDING _____ B. WING _____	02/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHED BY A WHITE DOVE ASSISTED LIVIN	1605 CARDENAS DRIVE NE ALBUQUERQUE, NM 87110

(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
A66	Continued From page 37 REQUIREMENTS (NMAC 7.1.13, EFFECTIVE February 28, 2006) FOR 2 OF 2 DIRECT CARE STAFF (E1 AND E2). THE FINDINGS ARE: DURING REVIEW OF THE EMPLOYEE FILES IT WAS NOTED THE FOLLOWING REQUIRED TRAINING CURRICULUM DOCUMENTATION WAS MISSING: ON 2/28/07 AT 11:35AM DURING THE EXIT INTERVIEW, THE ADMINISTRATORS ACKNOWLEDGED THE PROBLEM. REFER TO NMAC 7.1.13.10(C2-3) - ABUSE, NEGLECT AND EXPLOITATION TRAINING TIMEFRAME BASED ON RECORD REVIEW AND INTERVIEW, THE FACILITY FAILED TO ENSURE TRAINING ON ABUSE, NEGLECT AND MISAPPROPRIATION OF PROPERTY IN ACCORDANCE TO THE REGULATIONS SET FORTH IN THE INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS (NMAC 7.1.13, EFFECTIVE February 28, 2006) FOR 2 OF 2 DIRECT CARE STAFF (E1 AND E2). THE FINDINGS ARE: DURING REVIEW OF THE EMPLOYEE FILES IT WAS NOTED THE FOLLOWING REQUIRED TRAINING DOCUMENTATION WAS MISSING: -E1: REPORTING REQUIREMENTS FOR ABUSE, NEGLECT AND EXPLOITATION -E2: REPORTING REQUIREMENTS FOR ABUSE, NEGLECT AND EXPLOITATION	A66	Training curriculum documentation has been received & implement immediately & is on file 2 of 2 direct care staff have under gone Training & will receive reviewed training Bi annually- any new employee will receive training within 30 days of employment and after Bi annually completed 3-07 Training for 2 of 2 direct care staff was completed & documentation of training on file will continue B-annually 3-23-07	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5827	A. BUILDING _____ B. WING _____	02/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHED BY A WHITE DOVE ASSISTED LIVIN	1605 CARDENAS DRIVE NE ALBUQUERQUE, NM 87110

(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
A66	Continued From page 38 ON 2/28/07 AT 11:35AM DURING THE EXIT INTERVIEW, THE ADMINISTRATOR ACKNOWLEDGED THE PROBLEM. REFER TO 7.1.13.10(F) - POSTING OF INCIDENT MANAGEMENT POSTER BASED ON OBSERVATION AND INTERVIEW, THE FACILITY FAILED TO POST REQUIRED REPORTING POSTERS FROM THE INCIDENT MANAGEMENT BUREAU AS SET FORTH IN THE INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS (NMAC 7.1.13, EFFECTIVE February 28, 2006) FOR 2 OF 2 DIRECT CARE STAFF (E1 AND E2). THE FINDINGS ARE: ON 2/26/07 AT 11:00AM DURING A TOUR OF THE FACILITY, IT WAS NOTED THAT THE ABUSE, NEGLECT AND EXPLOITATION POSTERS FROM DIVISION OF HEALTH IMPROVEMENT, INCIDENT MANAGEMENT BUREAU WERE NOT POSTED CONSPICUOUSLY. ON 2/28/07 11:35AM DURING THE EXIT INTERVIEW, THE ADMINISTRATOR STATED THAT SHE WOULD HANG THE POSTERS.	A66	Abuse neglect and exploitation posters have been obtained from division of health improvement incident management bereau posters have been posted conspicuously and will remain from this date forward 3-07	