STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2102	A. BUILDING _____ B. WING _____	03/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW VISION SANTA FE, LLC	500 RODEO ROAD SANTA FE, NM 87505

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 01	OPENING REMARKS Surveyor: 22585 The findings in Citation 001 - Opening Remarks include information discovered but will not be considered a deficient practice for the purpose of this survey. Development of internal policies, procedures, protocols and staff training designed to meet the facility's unique business needs and clientele may be considered in the interest of responsible resident care. Based on record review and interviews, the facility has not submitted all employee names and identifying information to Caregivers Criminal History Screening Program for background check. The findings are: A. During review of sampled employee files, the following was noted: -sampled files had copies of background checks as required by the facility for the purposes of employment per facility Human Resource procedure -specifically non-direct care employees did not have clearance letters nor documentation that this information has been submitted to Caregivers Criminal History Screening Program B. On 3/25/08 at 5:30 PM during review of the facility's employee handbook, it reads that: "certain" positions within the facility [do] require a background check. No specific criteria for screening nor specific position listed for screening/not screening were listed. C.. On 3/25/08 at 3:00 PM during interview with S2 and S3, S2 and S3 confirmed that the facility is not screening all employees under CCHSP.	A 01	Scanned 4/29/08	

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — General Manager — 4/24/08 (X6) DATE

STATE FORM 6899 4S5W11 If continuation sheet 1 of 29

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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	**A13** **Section: 7.8.2.13(B)(4)** **Violation:** Facility failed to ensure that records presented to the licensing authority were not misrepresentations or falsifications. **Corrective Actions:** There was no attempt, nor was there any intention of the facility or staff to present to the survey team documents that were falsified, misleading or misrepresenting. Certain documents appear to have been inadvertently included in documents presented to the survey team, and the facility understands how these documents could be construed to be an attempt to mislead or falsify. All employees have been instructed on the importance of assuring compliance with facility policies and procedures and maintaining records in compliance with federal state and local laws using knowledge of regulatory standards. Employees will receive on-going guidance of facility standards for timely, clear and accurate documentation and reporting. Employees were reminded of the potential consequences of violations of this section, and informed that any such violation would result in disciplinary action up to and including dismissal. *(Continued on page 3)*	

General Manager 4/24/08

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A13	Continued From page 2 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: Surveyor: 22585 Refer to 7.8.2.13(B)(4) - Grounds for Revocation of license or Imposition of sanctions or Civil Monetary Penalties pertaining to Falsification of Fire Drill Records Based on record reviews and interviews, the facility failed to ensure that records presented to the licensing authority were not misrepresentations or falsifications. The findings are: A. On 3/14/08 during entrance conferences with S2 and S6, a basic list of documents needed to conduct the annual survey was provided. On this list was noted fire drill documentation request. B. On 3/14/07 at 2:00 PM during review of what was presented by S1 as the facility fire drill log, it was noted that there was no documentation for drills for the following: 7/07, 11/07 and 12/07. C. On 3/14/08 at 4:30 PM during re-review of the fire drill log, the following was noted with respect to drill documentation designated as being done during months of 1/08 and 2/08: -the two sheets were signed in the same descending order by the same seven (7) persons -a portion of each of the two sheets was "covered	A13	*(Continued from page 2)* **Identification of other residents potentially affected:** No residents are directly affected. **Monitoring of Corrective Action:** Facility administrator or his/her designee will periodically review documentation/reporting of each department to ensure that information gathered is accurate and complete. **Completion Date:** April 24, 2008	4-24-08

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A13	Continued From page 3 up" with correction fluid (white out) -there were no comments in the 'comment' section of either of the forms -neither dated sheet indicated whether or not the fire alarm had been activated for the drill as required D. On 3/25/08 at 11:00 AM during a confidential group interview, the following was reported as a group consensus -subsequent to the fire drill conducted during 3/08 , the group was called together to "sign" 3 pages presented to them which was explained to them as "documentation needed for the 3/08 drill". All 7 persons signed off on the blank sheets. -When presented with photocopies of what was presented to the survey team as 1/08 and 2/08 fire drill documentation, the group consensus was that no fire drills had been conducted for those months and that sheets signed off on were "blank" at the time they were signed. E. On 3/25/08 during review of the [Fire] Alarm Activity Report for dates 1/26/08 and 2/6/08, this report did not indicate that the facility fire alarm had been triggered for the purposes of a fire drill as required by regulations. It did however, indicate the Alarm company's routine 24 hour check (indicating functional alarm) on both of those days. F. Review of S1's job description on 3/25/08 at 2:00 PM, S1 is charged with overseeing safety by assuring compliance with [facility] policies and procedures and maintaining records in compliance with federal, state and local laws using knowledge of regulatory standards. G. On 3/25/08 between 2:21 and 2:30 PM during interview with S1, SI confirmed the following:	A13		

General Manager 4/24/08

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A13	Continued From page 4 -S1 confirmed that forms (presented for viewing during interview) were being used to document facility fire drills. -S1 admitted that fire drills were not conducted for the months of 7/07, 11/07, 12/07, 1/08 and 2/08. -S1 said that the documents presented to the survey team were "for training" purposes and that "other documents" for these drills were being kept by S2 (who was not present at the facility during this interview) but that these documents were not supposed to be for given to the survey team. -S1 admitted that the appearance of the documents did give the impression of falsification. -S1 stated that the "whited out" portion of the documents was "done by the 'guys'" S1 supervises and S1 "didn't know why". -During this interview, S1 did not elaborate on the topic of fire drills when asked to discuss regulatory requirements for fire drills and all required fire drill documentation elements. -Finally, S1 stated that other drill documentation would be provided by S2 H. On 3/25/08 at 2:25 PM during interview with S3, S3 stated that all survey documentation had already been provided to the survey team. I. On 3/25/08 at 3:00 PM during interviews with S2 and S3, no further documentation regarding fire drills was mentioned by S2 or S3 nor was any other documentation provided to the survey team.	A13		
A20	7 NMAC 8.2.20 ADMISSIONS/DISCHARGE AGREEMENT 7.8.2.20 ADMISSION/DISCHARGE AGREEMENT: The facility must establish an admission agreement for each resident.	A20	**A20** **Section: 7.8.2.20(A)(2-3); 7.8.2.20(B)** **Violation:** Facility failed to provide an admission agreement with specific in- *(Continued on page 6)*	

General Manager 4/24/08

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A20	Continued From page 5 A. The admission agreement must include the following information: (1) The parties to the agreement. (2) The scope of services to be provided. (3) The cost of services and method of payment. (4) The circumstances under which the Agreement may be terminated. (a) Termination of admission agreements shall be upon at least fifteen (15) days written notice, to the resident and his or her agent or guardian, where applicable, unless the resident requests termination. (b) The facilities bed hold policy. (c) An admission/discharge agreement may provide for termination by the facility when the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility. (d) Termination of an admission agreement by the facility is permitted in emergency situations for the following reasons: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; the safety or health of individuals in the facility is endangered; the resident has failed to pay for a stay at the facility, as defined in the admission agreement; the facility ceases to operate or is no longer able to provide services to the resident; and due to sanctions or remedies imposed by the Department. B. A new or amended admission agreement must be executed whenever services, costs or other material terms are changed. [7-11-86, 1-11-90, 4-7-97; 7.8.2.20 NMAC - Rn, 7 NMAC 8.2.20, 8-31-00] This REQUIREMENT is not met as evidenced by:	A20	*(Continued from page 5)* formation about all services provided by the facility and the scope of those services, how those services would be provided, their costs, and advance written notice of any changes/ clarifications. **Corrective Actions:** Marketing and leasing materials are being revised to provide greater clarity and explanation about the services provided, and the costs thereof, particularly as it relates to food service, bathing facilities, and terms of agreement. The facility is also reviewing marketing materials to ensure that descriptions of services, costs, etc. conform to leases, addendums thereto, and other contractual documents. Changes in level of care are currently discussed with consumers and/or their representatives, including the reasons for the change and the related costs. At the time the consumer or their family/authorized representatives are informed of a change in the level of care the facility obtains a signed acknowledgement and authorization. With the exception of level of care changes discussed above, the facility will communicate all future changes in either services or costs to all residents at least 30 days in advance of the effective date, and will obtain a signed *(Continued on page 7)*	

General Manager 4/24/08

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A20	Continued From page 6 Surveyor: 22585 Refer to 7.8.2.20(A)(2-3) - Admission Agreement Refer to 7.8.2.20(B) - Amendments to admission agreements Based on observation, record review, and interview, the facility failed to provide an admission agreement with specific information about all services provided by the facility and the scope of those services, how those services would be provided, their costs and advance written notice of any changes/clarifications. This has the potential to negatively impact 100% of the resident population. The findings are: A. On 3/14/08 during lunch observation, it was noted that the assisted living residents had widely ranging types of foods being given to them to eat by staff members. B. On 3/14/08 during lunchtime interview with S19, S19 stated that the residents order meals the evening prior for all of the next days meals. C. On 3/14/08 at 1:00 PM during interview with R4, R4 stated that not all menus available to residents were being presented to residents to order from for meal service as was marketed to the resident prior to moving into the facility. D. On 3/18/08 at 8:15 AM during review of R4's medical record, it indicated that R4 had no diagnosis of dementia, was mentally oriented to person, time and place. E. On 3/14/08 at 3:50 PM during interview with S9, S9 reported that there were "problems with the existing service agreement" to include lack of clarity about various services to be provided [to	A20	*(Continued from page 6)* lease amendment from each consumer, their family or legal representative whenever services, costs or other material terms are changed. Business office procedures have been modified so that fee increases are required to be documented with either an executed lease amendment or an executed level of care change. **Identification of other residents potentially affected:** This deficiency potentially affects 100% of residents. The corrective action described above addresses all potentially affected residents. **Monitoring of Corrective Action:** The facility administrator or his/her designee will periodically review marketing materials to ensure conformity with current leasing documents. Business office staff will periodically review lease files to confirm that current billing amounts conform to executed lease documents. **Completion Date:** May 10, 2008	5-10-08

Renewal Manager 4/24/08

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A20	Continued From page 7 the residents]. Some of the specific issues mentioned by S9 during this conversation were: -food service -term of agreement -bathing facilities -"hold over" clause F. On 3/20/08 at 3:00 PM with S9 and S28, they confirmed that the lease information was not clear and specific with regard to services provided versus information provided as part of the marketing package. During this interview, S9 confirmed that the facility has not notified residents of any changes in service costs nor changes in availability of services. G. On 3/26/08 at 1:00 PM during confidential interview with a family member of a resident, the family member reported that there had been problems with clarity regarding issues related to the admission agreement of the resident including: -meals -charges for LOC (Level of Care)	A20		
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.	A23	**A23** **Section: 7.8.2.23(A)(11)** **Violation:** Facility failed to ensure that staff training records were kept as required. (safe food handling practices) **Corrective Actions:** The facility will conduct training for all employees involved in the handling of food. Attendance at the training will be mandatory. The facility will obtain from each em- *(Continued on page 9)*	

General Manager 4/24/08

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A23	Continued From page 8 (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 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.	A23	*(Continued from page 8)* ployee in attendance a signed statement indicating the date, time and place that they received their safe food handling practices instruction. This documentation will become a permanent part of the employee's record. All new employees who receive training in safe food handling practices as part of their initial orientation will document their attendance at the training as described above. On at least an annual basis a refresher/update training will be held for all employees whose duties involve handling of food. Documentation as described in the preceding paragraph will be obtained. **Identification of other residents potentially affected:** This deficiency potentially affects 100% of residents. The corrective action described above addresses all potentially affected residents. **Monitoring of Corrective Action:** The director of human resources or their designee will review personnel files periodically to ensure that all employees have documented attendance at safe food handling practices training dated within one year of the date of review. **Completion Date:** April 24, 2008	4-24-08

General Manager 4/24/08

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A23	Continued From page 9 (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. 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	A23		

General Manager 4/24/08

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A23	Continued From page 10 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 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	A23		

General Manager 4/24/08

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A23	Continued From page 11 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: Surveyor: 22585 Refer to 7.8.2.23(A)(11) - Facility Records pertaining to Staff Training Based on record review and interview, the facility failed to ensure that staff training records were kept as required for sampled files (S24, S25, S27, and S30). The findings are: On 3/25/08 at 8:00 AM during review of sampled employee files, it was noted that none contained documentation relating to 2008 Incident Management or Safe Food Handling as appropriate to their respective job assignments. On 3/25/08 between 8:30 AM and 8:48 AM during interviews with S1, S4 and S26, they report that they conduct on-the-job trainings for employees but currently do not keepany documentation of topics covered or dates of training. They report that training is either "at hire", "as needed" or "constantly reinforced" but acknowledged that they don't keep documentation of these trainings.	A23		
A34	7 NMAC 8.2.34 RESIDENT RIGHTS 7.8.2.34 RESIDENT RIGHTS: All licensed 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	A34	**A34** **Section: 7.8.2.34(D)(3)** **Violation:** Facility failed to protect resident rights by furnishing residents *(Continued on page 13)*	

4/24/08 General Manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2102	A. BUILDING _____ B. WING _____	03/25/2008

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A34	Continued From page 12 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 and sanitary living environment. (5) Provide humane care. (6) Assure the resident's rights to privacy in medical care, including privacy during medical	A34	*(Continued from page 12)* with specific information about all services provided by the facility, how those services would be provided, their costs with advance written notice of any changes/clarifications. **Corrective Actions:** Marketing and leasing materials are being revised to provide greater clarity and explanation about the services provided, and the costs thereof, particularly as it relates to food service, bathing facilities, and terms of agreement. The facility is reviewing marketing materials to ensure that descriptions of services, costs, etc. conform to leases, addendums thereto, and other contractual documents. Changes in level of care are currently are discussed with consumers and/or their representatives, including the reasons for the change and the related costs. At the time the consumer or their family/authorized representatives are informed of a change in the level of care the facility obtains a signed acknowledgement and authorization. With the exception of level of care changes discussed above, the facility will communicate all future changes in either services or costs to all residents at least 30 days in advance of the effective date, and will obtain a signed lease amendment from each consumer, their family or legal representa- *(Continued on page 14)*	

General Manager 4/24/08

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A34	Continued From page 13 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. (16) Provide services consistent with informed consent. (17) Assure that all residents may voice grievances to the facility staff, public officials, the	A34	*(Continued from page 13)* tive whenever services, costs or other material terms are changed. **Identification of other residents potentially affected:** This deficiency potentially affects 100% of residents. The corrective action described above addresses all potentially affected residents. **Monitoring of Corrective Action:** The facility administrator or his/her designee will periodically review marketing materials to ensure conformity with current leasing documents. Business office staff will periodically review lease files to confirm that current billing amounts conform to executed lease documents. **Completion Date:** May 10, 2008	5.10.08

General Manager 4/29/08

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A34	Continued From page 14 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 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	A34		

General Manager 4/24/08

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A34	Continued From page 15 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: Surveyor: 22585 Refer to 7.8.2.34 (D)(3) - Protect the rights of all residents. Based on observation, record review, and interview, the facility failed to protect residents rights by furnishing residents with specific information about all services provided by the facility, how those services would be provided, their costs with advance written notice of any changes/clarifications. The findings are: A. On 3/14/08 during lunch observation, it was noted that the assisted living residents had widely ranging types of foods being given to them to eat by staff members. B. On 3/14/08 during lunchtime interview with S19, S19 stated that the residents order meals the evening prior for all of the next days meals. C. On 3/14/08 at 1:00 PM during interview with R4, R4 stated that not all menus available to residents were being presented to residents to order from for meal service as was marketed to the resident prior to moving into the facility. D. On 3/18/08 at 8:15 AM during review of R4's medical record, it indicated that R4 had no diagnosis of dementia, was mentally oriented to person, time and place. E. On 3/14/08 at 3:50 PM during interview with	A34		

General Manager 4/24/08

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A34	Continued From page 16 S9, S9 reported that there were "problems with the existing service agreement" to include lack of clarity about various services to be provided [to the residents]. Some of the specific issues mentioned by S9 during this conversation were: -food service -term of agreement -bathing facilities -"hold over" clause F. On 3/20/08 at 3:00 PM with S9 and S28, they confirmed that the lease information was not clear and specific with regard to services provided versus information provided as part of the marketing package. During this interview, S9 confirmed that the facility has not notified residents of any changes in service costs nor changes in availability of services. G. On 3/25/08 at 1:00 PM during confidential interview with a family member of a resident, the family member reported that there had been problems with clarity regarding issues related to the admission agreement of the resident including: -meals -charges for LOC (Level of Care)	A34		
A37	7 NMAC 8.2.37 NUTRITION 7.8.2.37 NUTRITION: Each facility shall provide planned and nutritionally balanced meals in accordance with the recommended daily dietary allowance from the basic food groups to meet the nutritional needs of the age group. A. At least three (3) meals shall be served daily at regular times, or in accordance with the program narrative. (1) No more than a sixteen (16) hour span may exist between a substantial evening	A37	**A37** **Section: 7.8.2.37** **Violation:** Facility failed to ensure that snacks were available between meals and in the evening. *(Continued on page 18)*	

General Manager 4/24/08

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A37	Continued From page 17 meal and breakfast. Snacks must be made available between meals and in the evening and must be listed on the daily menu. Vending machines shall not be considered a source of snacks. (2) A sufficient amount of time shall be allowed for meals to enable residents to eat at a leisurely pace and to socialize. B. A copy of the current week's menu, including snacks and therapeutic diets, shall be posted where residents and families can see it. Posted menus shall be followed and any substitution must be of equivalent nutritional value and recorded on the posted menu. Menus as served must be kept for thirty (30) days and be available to the public. Identical menus shall not be used on a one (1) week cycle basis. C. Therapeutic diets and prescribed vitamin and mineral supplements shall be given and served only on the written orders of a physician. The physician's order shall become part of the resident's record and shall be updated as necessary. D. The facility shall make every reasonable attempt to accommodate the resident's food preferences, and requests by the resident or the resident's representative to observe religious or cultural dietary practices. E. Personnel handling food must be in good health , practice hygienic food-handling techniques, have good personal grooming, and be free from communicable disease transmissible via food. F. Ensure the food is prepared by methods that will conserve nutritive value, enhance flavor, appearance, and is served at the proper temperature and in a form to meet individual needs. G. All residents must be served in a dining room except for residents with a temporary	A37	*(Continued from page 17)* **Corrective Actions:** Effective immediately a supply of fresh fruit, in addition to prepared snacks will be maintained and made available on the unit in order to ensure that snacks are available between meals and in the evening. Kitchen staff will be responsible for monitoring stock levels, and replenishing/requisitioning as necessary. **Identification of other residents potentially affected:** This deficiency potentially affects 100% of residents. The corrective action described above addresses all potentially affected residents. **Monitoring of Corrective Action:** Director of Wellness will monitor the availability of snacks, and will report to the Administrator/General Manager any issues related to their availability. **Completion Date:** April 24, 2008	4-24-08

General Manager 4/29/08

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A37	Continued From page 18 illness, or documented specific personal preference. H. If a resident consistently refuses to eat after encouragement, the resident shall be evaluated by an appropriate health professional. The resident shall be offered fluids more often during the time he/she is refusing to eat. [7-1-64, 9-15-70, 5-26-72, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.37 NMAC - Rn, 7 NMAC 8.2.37, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 22585 Refer to 7.8.2.37 - Snacks Based on record review and interview, the facility failed to ensure that snacks were available between meals and in the evening. The findings are: A. On 3/17/08 at 3:02 PM during interview with S12, she reported that snacks were not being made available consistently in terms of quantity and sometimes not at all. Specifically reported were 3/1/08 when "5 small pieces of brownies and 6 oatmeal cookies 'cut in half' " were delivered as the snack for 10 residents and on 3/9/08, 3/15/08 and 3/16/08 when no snacks were brought at all. B. On 3/17/08 during review of facility snack lists, the facility showed a "snack plan" had been developed. However, no documentation was presented that snacks had been prepared by culinary department and signed for in activity department. In addition, no where on the snack menus provided was any documentation (notes) to account for the brownies/cookies delivered on 3/1/08 nor any snack lists presented "as served."	A37		

General Manager 4/24/08

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A56	7 NMAC 8.2.56 TOILET AND BATHING FACILITIES 7.8.2.56 TOILET AND BATHING FACILITIES: A. A minimum of one (1) toilet, one (1) sink and one (1) bathing unit must be provided for every eight (8) residents or fraction thereof. Each facility shall provide at least one tub and one shower or combination unit to allow for residents bathing preference. B. The combination type tub and shower is permitted. C. toilets, tubs, and showers must be provided with grab bars. D. If a facility has live in staff, a separate toilet, sink, and bathing facility must be provided. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have a separate toilet, sink, and bathing facility for live in staff. E. Tubs and showers must have a slip resistant surface. F. Toilet, sink, and bathing facilities must be readily available to the residents. No passage through a resident room by another resident to reach a toilet, bath, or sink facility is permitted. G. All facilities must have a minimum of one (1) toilet and bathing facility which meets requirements for the disabled. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have a toilet and bathing facility which meets requirements for the disabled. H. Toilet paper and soap must be provided in each toilet room. I. The use of a common towel is prohibited. J. Bathrooms and lavatories must be cleaned as often as necessary to maintain a clean and sanitary condition. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.56 NMAC - Rn, 7 NMAC, 8-31-00]	A56	**A56** **Section: 7.8.2.56(A)** **Violation:** Facility failed to ensure that a functional tub was available to allow for residents bathing preference. **Corrective Actions:** The facility will negotiate and enter into a service agreement with an appropriate vendor so that routine maintenance will take place in accordance with manufacturer specifications, and emergency repairs will be made in a timely manner. Facility staff will notify maintenance in the event of any operating problems. Residents will be familiarized with the operation and use of the tub facility, and will receive assistance as required or requested Finding A-56 A is disputed. R4 is the only resident that appears to have had or has reported difficulty using the tub facility. The issues described in Finding A-56 C do not affect the functionality of the spa tub. The unit was installed in conformity with manufacturer specifications. The service technician's handwritten notes of "problems" represent his opinion only, and do not represent the manufacturer's requirements for safe and proper installation and functionality of the unit. *(Continued on page 21)*	

Renee Mange 4/24/08

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A56	Continued From page 20 This REQUIREMENT is not met as evidenced by: Surveyor: 22585 Refer to 7.8.2.56 (A) - Toilet and Bathing Facilities - A tub or combo unit must be made available to allow for resident bathing preference. Based on record review and interviews, the facility failed to ensure that a functional tub was available to allow for residents bathing preference. The findings are: A. On 3/20/08 during interview with R4, R4 stated that one of the reasons for choosing the facility was the "spa tub" in the assisted living area. However, R4 reported that during all attempts to use the tub, it has not functioned properly since January 2008. B. On 3/19/08 between 2:21 PM and 2:30 PM interview with S2, S8 and S9, they confirm that there is no other tub facility for any of the residents to use anywhere on the premises other than the "spa tub" in the assisted living area. During this interview, S8 reports that the spa tub is not predictably functional for use. C. Review of work order for the spa tub dated 3/12/08 indicated that the tub seal was not holding, that the bladder was not holding and that there were issues with the lock at the bottom of the door. While these issues were worked on by the technician when he was on site, handwritten tech notes indicate that there is currently no access to the back of the tub, that the tub is not anchored to the floor and the current drain is not run to an open catch basin. Tech notes indicate that the first three items are "problems" that "must be taken care of." No documentation or	A56	*(Continued from page 20)* **Identification of other residents potentially affected:** This deficiency potentially affects 100% of residents. The corrective action described above addresses all potentially affected residents. **Monitoring of Corrective Action:** Regularly scheduled routine maintenance visits will be added to future calendars. Facility maintenance staff will test unit for proper functioning at least one per calendar quarter to ensure that unit is in good working order. **Completion Date:** Service agreement will be finalized by May 1. Other actions will be completed by April 24, 2008.	5·1·08

General Manager 4/24/08

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A56	Continued From page 21 information was provided to the survey team to indicate that these issues were resolved nor how they affected the functionality of the spa tub.	A56		
A61	7 NMAC 8.2.61 AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM 7.8.2.61 AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Where an automatic fire protection (sprinkler) system is installed for total or partial coverage, the system shall be in accordance with NFPA 13 or NFPA 13D as applicable. [4-7-97; 7.8.2.61 NMAC - Rn, 7 NMAC 8.2.61, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 22585 Refer to 7.8.2.61 - Sprinkler System AUTOMATIC FIRE PROTECTION (SPRINKLER SYSTEM: Maintenance of system: Reference NFPA 13, Section 1-5.1 Maintenance: A sprinkler system installed under this standard shall be properly maintained for efficient service. The owner is responsible for the condition of the sprinkler system and shall use due diligence in keeping the system in good operating condition. Reference NFPA 13 Section 4-5.5.2.1 Continuous or non-continuous obstructions less than eighteen (18) below the sprinkler deflector that prevents the pattern from fully developing shall comply with this section. Section 4-5.5.3 Continuous or noncontinuous obstructions that interrupt the water discharge in	A61	**A61** **Section: 7.8.2.61** **Violation:** Facility's practice failed to ensure that the sprinkler system is professionally maintained. **Corrective Actions:** Maintenance and kitchen procedures have been modified to ensure that range hood sprinklers are cleaned on at least a weekly basis and kept free of grease residue **Identification of other residents potentially affected:** This deficiency potentially affects 100% of residents and staff. The corrective action described above addresses all potentially affected residents and staff. **Monitoring of Corrective Action:** Visual inspection of range hood sprinklers has been added to maintenance checklists. **Completion Date:** 4/24/2008	4-24-08

General Manager 4/24/08

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A61	Continued From page 22 a horizontal plane more than eighteen (18) inches below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with this section. Section 4-5.6 requires that the clearance between the deflector and the top of storage shall be eighteen (18) inches or greater. Reference NFPA 25, 1-4.2 The responsibility for properly maintaining a water-based fire protection system shall be that of the owner(s) of the property. By means of periodic inspections, tests, and maintenance, the equipment shall be shown to be in good operating condition, or any defects or impairments shall be revealed. Inspection, testing, and maintenance shall be implemented in accordance with procedures meeting or exceeding those established in this document and in accordance with the manufacturer's instructions. These tasks shall be performed by personnel who have developed competence through training and experience. Based on observation and interviews, the facility's practice failed to ensure that the sprinkler system is professionally maintained affecting all residents and staff throughout the facility. The findings are: A. On 3/17/08 during tour of the facility kitchen with S5, it was noted that range hood sprinklers were covered in what appeared to be black grease residue. At that time, S5 reported that "the dishwasher" was charged with cleaning the elements kitchen hood area. B. On 3/18/08 at 7:00 AM during subsequent tour of the facility kitchen, it was noted that the range	A61		

General Manager 4/24/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2102	A. BUILDING _____ B. WING _____	03/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW VISION SANTA FE, LLC	500 RODEO ROAD SANTA FE, NM 87505

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A61	Continued From page 23 hood sprinklers were no longer covered in black grease residue. C. On 3/18/08 at 7:00 AM during confidential interview staff reported that all range hood elements are cleaned "by the dishwasher".	A61	**A63** **Section: 7.8.2.63(D)** **Violation:** Facility failed to ensure that at least one fire drill was conducted for the assisted living area each month. **Corrective Actions:** Fire drills will be conducted each month and will be held at different times of the day so that there will be one drill per shift per calendar quarter. The scheduled drill for April has been conducted. For each drill documentation will be maintained noting the date and time, number of personnel participating, evacuation time in total minutes, and notes of any problems encountered. The environmental services director will coordinate scheduling of fire drills with the facility administrator and the director of wellness. The environmental services director will also coordinate with local fire authorities to request their supervision and participation of at least one drill per year. **Identification of other residents potentially affected:** This deficiency potentially affects 100% of residents. The corrective action described above addresses all potentially affected residents. **Monitoring of Corrective Action:** Each month the environmental services director will provide the facility *(Continued on page 25)*	
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 times of the day. (2) The fire alarm system or detector system in the facility shall be used in the conduct of fire drills.	A63		

General Manager 4/29/08

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A63	Continued From page 24 (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: Surveyor: 22585 Refer to 7.8.2.63(D) - Minimum of one (1) fire drill per month Based on record reviews and interview, the facility failed to ensure that at least one fire drill was conducted for the assisted living area each month. The findings are: On 3/14/07 at 2:00 PM during review of what was presented by S1 as the facility fire drill log, it was noted that there was no documentation for drills for the following: 7/07, 11/07 and 12/07. Review of S1's job description on 3/25/08 at 2:00 PM, S1 is charged with overseeing safety by assuring compliance with [facility] policies and procedures and maintaining records in compliance with federal, state and local laws using knowledge of regulatory standards. On 3/25/08 at 2:30 PM during interview with S1,	A63	*(Continued from page 24)* administrator with a report on the current month's fire drill, and the scheduled date for the following months drill. **Completion Date:** April 24, 2008	4-24-08

General Manager 4/24/08

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A63	Continued From page 25 SI confirmed the following: S1 confirmed that forms presented for viewing during interview were being used to document fire drills. S1 admitted that drills were not conducted for the months of 7/07, 11/07, 12/07, 1/08 and 2/08. S1 further stated that documentation presented lacked the time of the drill and participating resident signatures for the 1/08 and the 2/08 drills. Finally, during this interview, S1 did not elaborate on the topic when asked to discuss regulatory requirements for fire drills and all required fire drill documentation elements.	A63		
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: Surveyor: 22585 Refer to NMAC 7.1.13.10(C)(1)(a-f) Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Incident Management System Training	A66	**A66** **Section: 7.1.13.10(C)(1)(a-f);** **Violation:** Facility failed to ensure up-to-date training on Incident reporting, Intake, Processing and Training Requirements. **Corrective Actions:** The facility will conduct incident management training, consistent with the 2008 Incident Management Training Curriculum. All current employees will be required to attend. In addition, there will be a monthly training for all new employees hired within the preceding 30 days. Effective immediately, at least one representative from the facility will attend the statewide Incident Management *(Continued on page 27)*	

General Manager 4/29/08

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A66	Continued From page 26 Curriculum Requirements Based on record review and interview, the facility failed to ensure up-to-date training on Incident Reporting, Intake, Processing and Training Requirements with the required curriculum for sampled files (S24, S25, S27, and S30). The findings are: A. On 3/24/08 at 9:26 AM during review of the facility assisted living policy and procedure, it noted the following under "Instructions for using the Incident Management System Training...": -withing 30 days of new hires and by May 28, 2006, for all existing employees, all residents, family members, legal guardians and case managers, read and discuss the above inservice training and policy and procedures. B. On 3/25/08 at 8:00 AM during review of the employee files it was noted that the required training documentation for incident reporting and processing requirements was not in the files for S24, S25, S27, and S30. C. On 3/19/08 during interview with S2, S2 reported that the facility curriculum and policy and procedures were outdated for Incident Management. S2 further reported that no one from the facility had attended the statewide Incident Management Training for the 2008 curriculum. Refer to NMAC 7.1.13.10(D) Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Requirement	A66	*(Continued from page 26)* Training for the annual curriculum update. Effective immediately, the facility will conduct an annual Incident Management training for all staff. This training will occur within 30 days of the statewide training referred to above. **Identification of other residents potentially affected:** No residents are directly affected by this issue. **Monitoring of Corrective Action:** The facility administrator, director of wellness or their designees will monitor communication from the state for the date of the statewide training. Evidence of attendance at the statewide training will be placed in the personnel file of the appropriate employee. The director of human resources or their designee will review personnel files periodically to ensure that all employees have documented attendance at incident management training within one year of the date of review. **Completion Date:** April 24, 2008 **A66 Section: 7.1.13.10(D)** *(Continued on page 28)*	4/24/08

General Manager 4/24/08

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A66	Continued From page 27 to maintain documentation of Incident Management Training for all employees Based on record review and interview, the facility failed to ensure required documentation of training on Incident Management for sampled staff files (S24, S25, S27, and S30). The findings are: A. On 3/24/08 at 9:26 AM during review of the facility assisted living policy and procedure, it noted the following under "Instructions for using the Incident Management System Training...": -withing 30 days of new hires and by May 28, 2006, for all existing employees, all residents, family members, legal guardians and case managers, read and discuss the above inservice training and policy and procedures. B. On 3/25/08 at 8:00 AM during review of the employee files it was noted that the required training documentation for incident reporting and processing requirements was not in the files for S24, S25, S27, and S30. C. On 3/25/08 at 8:45 AM during interview with S4, S4 discussed the facility's internal processfor handling incidents and use of internal forms and made no mention of the processes, regulations, forms or training associated with the Incident Management process. D. On 3/25/08 at 8:30AM during interview with S26, S26 reports that the department conducts on-the-job training. S26 discussed how Incident Management is akin to "customer service" but did not discussthe processes, regulations, reporting requirements, forms or training associated with the Incident Management process.	A66	*(Continued from page 27)* **Violation:** The facility failed to ensure required documentation of training on Incident Management. **Corrective Actions:** Effective immediately the facility will obtain from each employee attending incident management training pursuant to NMAC 7.1.13.10 a signed statement indicating the date, time and place that they received their incident management reporting instruction. This documentation will become a permanent part of the employee's record. **Identification of other residents potentially affected:** No residents are directly affected. **Monitoring of Corrective Action:** Monitoring of this corrective action will be accomplished by periodic review of employee files by the facility administrator (or his/her designee) to verify that signed statements referred to above are in each file, evidencing both initial and on-going training. **Completion Date:** April 24, 2008	4.24.08

General Manager 4/24/08

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A66	Continued From page 28 E. On 3/26/08 at 8:51 AM during interview with S1, S1 states that the department does on-the-job training for safety. S1 described Incident Management as "situation control for falls and happenings". Refer to NMAC 7.1.13.10(E) - Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Consumer and Guardian Orientation Packet Based on record review and interview, the facility failed to ensure that documentation of notice to family members and/or guardians regarding incident reporting information was in facility lease agreement or other resident notifications. The findings are: A. On 3/25/08 at 1:00 PM during review of R11's file , it was noted that it had no documentation of notification to family members/guardians regarding Incident Management B. On 3/20/08 at 3:00 PM during interview with S9, S9 stated that no Incident Management information was provided during the leasing process.	A66	**A66** **Section: 7.1.13.10(E)** **Violation:** Facility failed to ensure that documentation of notice to family members and/or guardians regarding incident reporting information was in facility lease agreement or other notifications. **Corrective Actions:** Effective immediately all existing residents and/or their family members or guardians will be provided with an incident reporting packet which includes information about the incident reporting process as well as incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The facility will obtain from the appropriate consumer, family member or legal guardian a signed acknowledgement of receipt of this information, indicating date time and place received. The signed acknowledgement will be placed in the consumer's file. Effective immediately the above procedures will apply to new residents. This information will be provided during the leasing process, and will be reviewed during the orientation process. The signed acknowledgement referred to above will be obtained during the orientation process. **Identification of other residents potentially affected:** This deficiency potentially affects 100% of residents. The corrective action described above addresses all potentially affected residents. **Monitoring of Corrective Action:** Monitoring of this corrective action will be accomplished by periodic review of consumer files by the facility administrator (or his/her designee) to verify that signed acknowledgments referred to above are in each file. The acknowledgment will also be added to administrative checklists to ensure that staff (leasing and nursing) are reminded to provide the required information to consumers, family members and./or legal guardians. **Completion Date:** May 10, 2008	5.10.08

General Manager 4/24/08