STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2040	A. BUILDING _____ B. WING _____	08/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENNY'S SENIOR CARE	1504 37TH STREET SE RIO RANCHO, NM 87124

(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
A22	7 NMAC 8.2.22 Resident Records	A22		

7.8.2.22 RESIDENT RECORDS:

A. RESIDENT RECORDS, CONTENTS: A record for each resident shall be maintained with specific information required. Entries in each resident's record shall be legible, dated, and authenticated by the signature of the person making the entry. Resident records must include:

(1) Admission records as set out in Section 7.8.2.21 NMAC:

(2) Within five (5) days of admission:

(a) An executed admission agreement.

(b) A completed resident assessment form.

(c) Any available, admission physical examination report by a licensed health care professional, which may include all discharge information from another facility. When admission follows within thirty (30) days discharge from an acute care hospital, the hospital history and physical report, and the hospital discharge summary may serve as an admission physical.

(d) Names, addresses, relationship, and phone numbers of family members, and where appropriate, guardians, agents, and any surrogate decision makers.

(3) Within thirty (30) days of admission:

(a) A admission physical examination report by a licensed health care professional if an examination report was not available within five (5) days of admission.

(b) Resident's name, age, recent photograph, social security number, marital status, date of birth, sex, address prior to admission, religion (optional), personal physician, dentist, social history and designated representative or other emergency contact person, language spoken and understood, legal documentation relevant to commitment and/or guardianship status, present medications, and

ES scanned 09-04-08

Monica Dawson — LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Owner — (X6) DATE: 8-28-08

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A22	Continued From page 1	A22		

diet required.

(c) Any amendments to the admission agreement.

(d) The current completed resident assessment form.

(e) A completed and current individual service plan.

(f) Entries by direct care staff, appropriate health care professionals, or others authorized to care for the resident. Entries shall be dated and signed by the person making the entry and shall include significant information related to the individual service plan.

(g) Entries providing a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention, and entries reflecting appropriate follow-up. The maintenance of such written record in the resident record may be by copy of an incident/accident report, if the original incident/accident report is maintained elsewhere by the facility.

(h) A medication record: Medications administered by licensed personnel and/or staff assisting with medications to include: listing all currently ordered medications by name, dosage, administration times; documenting by medication name, dosage, date, and time, each medication administered, with the initials of the individual who administered or assisted with the medication; documentation of errors, omissions, and side-effects of medications; and written consent by resident or guardian for staff to assisting with medications.

(i) Date, time and progress note of health services provided by any contract agency.

(j) Unless included in the admission

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A22	Continued From page 2	A22		

agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures.

(k) Transfer forms completed, signed, and provided to accepting facility when resident is transferring to a hospital or another health care facility.

(l) Documentation of disposition of the resident's personal effects and money or valuables deposited with the adult residential care facility, upon death or transfer.

B. RESIDENT RECORDS, MAINTENANCE:

(1) Resident records shall be maintained and stored in an organized, accessible and permanent manner.

(2) The facility shall establish a policy for maintaining, and confidentiality of resident records, including the authorized release of resident records.

(3) Resident records must be maintained by the facility against loss, destruction, and unauthorized use for a period of not less than three (3) years from the date of discharge.

(4) There must be a policy and procedure in place for record retention in the event of facility closure.

[7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 7.8.2.22 NMAC - Rn 7 NMAC 8.2.22, 8-31-00]

This REQUIREMENT is not met as evidenced by:
7.8.2.22 A.(3) (h)

Based on record review and interview, the facility failed to document on the Medication Administration Record (MAR) entries with the

See attached for correction plan and date

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A22	Continued From page 3 initials of staff administering medications for 1 of 4 sampled residents . The findings are: A. During review of the Medication Administration Record (MAR) on 08/11/08, it was noted that on the Medication Administration Record (MAR) for the date of July 20, 2008, there were no entries with the initials of the staff administering the prn medication, APAP with codeine, take two tablets by mouth every six hours as needed for pain. B. During review of the narcotic log, it was noted that the last entry date of July 20,2008, for the medication APAP with codeine, take two tablets by mouth every six hours as needed for pain had not been initialed by the staff administering the prn medication. C. During the interview on 08/11/08 at 1:30 PM, with the Administrator, she acknowledged that the entries with the initials of the staff administering the medications were left blank.	A22		
A26	7 NMAC 8.2.26 Resident Assessment 7.8.2.26 RESIDENT ASSESSMENT: A. A resident assessment to determine level of function and if the client's needs can be met by the facility. The initial assessment must be completed within five (5) days of admission and reviewed every six (6) months as part of the individual service plan. B. The resident assessment must establish a baseline in the resident's functional status and thereafter, identify resident changes through periodic reassessments. C. The resident assessment must be documented on a state approved resident assessment form and at a minimum include the	A26	See attached sheet for plan of correction	

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A26	Continued From page 4	A26		

following:
(1) Cognitive patterns.
(2) Communication/hearing patterns.
(3) Vision patterns.
(4) Physical functioning and structural problems.
(5) Continence.
(6) Psycho social well-being.
(7) Mood and behavior patterns.
(8) Activity pursuit patterns.
(9) Disease diagnoses.
(10) Health conditions.
(11) Oral/nutritional status.
(12) Oral/dental status.
(13) Skin conditions.
(14) Medication use.
(15) Special treatment and procedures.

D. The resident admission assessment, the physical exam report, and the observation and evaluation of staff with regards to the needs will be used to develop the individual service plan, if needed. If the resident assessment does not indicate a need for an individual service plan, then an individual service plan is not required. However, an individual service plan must be prepared for residents requiring nursing services. [4-7-97; 7.8.2.26 NMAC - Rn, 7 NMAC 8.2.26, 8-31-00]

This REQUIREMENT is not met as evidenced by:
7.8.2.26 - Resident Assessment

Based on record review and interview, the facility failed to ensure that resident assessments were completed every six months as required for 4 of 4 sampled residents (Resident's #1,#2, #3 and #4).

The findings are:

A. On 8/11/08 at 2:00 PM, during review of the

see attached sheet for plan of correction

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A26	Continued From page 5 resident's records, it was noted that the resident assessments were not completed every 6 months for Resident #1,#2,#3,and #4. B. On 8/11/08 at 2:10 PM during interview, the administrator acknowledged that the assessments were not being done as required.	A26		
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 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	A36		

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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:
(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

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symptoms persist.

(e) Possible interactions or side-effects that might occur.

(f) Manufacturer's label information for directions if deemed adequate by the physician.

I. The facility must report all medication errors to the physician.

J. The facility shall develop and follow a written policy for unused, outdated, or recalled medications being kept in the facility.

[7-1-64, 9-15-70, 7019074, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.36 NMAC - Rn, 7 NMAC 8.2.36, 8-31-00]

This REQUIREMENT is not met as evidenced by:

7.8.2.36 F.(10)

Based on record review and interview, the facility failed to document on the Medication Administration Record (MAR) entries with the initials of staff administering medications for 1 of 4 sampled residents . The findings are:

A. During review of the Medication Administration Record (MAR) on 08/11/08, it was noted that on the Medication Administration Record (MAR) for the date of July 20, 2008, there were no entries with the initials of the staff administering the prn medication, APAP with codeine, take two tablets by mouth every six hours as needed for pain.

B. During review of the narcotic log, it was noted that the last entry date of July 20,2008, for the medication APAP with codeine, take two tablets by mouth every six hours as needed for pain had not been initialed by the staff administering the prn medication.

C. During the interview on 08/11/08 at 1:30 PM, with the Administrator, she acknowledged that

See attached sheets for plan of corrective

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A36	Continued From page 8 the entries with the initials of the staff administering the medications were left blank.	A36		
A66	7 NMAC 8.2.66 Related Regulations & 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: 7.8.2.66 Based on record review and interview the facility failed to have on site documentation that direct care staff had been cleared through the New Mexico Care Givers' Criminal History Screening (CCHS) Program(NMAC 7.1.9) for 1 of 4 employees (S2). The findings are: A. During record review, no documentation of clearance letter from the New Mexico Caregivers' Criminal History Screening Program (CCHS) was seen for(S2). B. During an interview on 08/11/08 at 1:45 PM,	A66	See attached sheets for plan of Correction	

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A66	Continued From page 9 with the administrator, she acknowledged that there was no clearance letter for S2. Based on record review and interview the facility failed to maintain documentation that the Employee Abuse Registry (EAR) was checked in accordance with NMAC 7.1.12 (effective January 1, 2006) for 4 of 4 employees (S1, S2,S3, and S4). The findings are: A. During review of the employee files it was noted that S1. S2, S3, S4, did not have on file documentation of a search of the registry using the individual's identifying information. B. During an interview on 011/08 at 2:30 PM with the administrator, she acknowledged that the registry search was not done for S1, S2. S3 and S4.	A66		