Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2200	A. BUILDING: _____ B. WING _____	C 03/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CIELOS ABIERTOS ASSISTED LIVING	3111 TOREADOR NE ALBUQUERQUE, NM 87111

(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 000	Initial Comments An annual survey and complaint investigation were completed for intake NM00029355 on 03/20/14 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was substantiated with deficiencies cited as a result of the investigation. Deficiencies were cited as a result of the annual survey.	A 000		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or	A 017	Scanned 5/22/14 DSB RECEIVED MAY 21 2014 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU	

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lauren M Figueroa — TITLE: Administrator — (X6) DATE: 5/21/2014

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A 017	Continued From page 1 exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.17 A. B. C. (1 through 12) and D. Based on record review and interview the facility failed to have records of staff training for 5 of 5 Ceregivers employed at the facility (#11 through #15). This widespread deficient practice could lead to harm of all 7 (#1 through #5, #7, and #8) of the facility residents to receive improper care or not receive needed care due to the caregivers not being trained. The findings are: A. Review of facility records revealed no training records for staff #11 through #15 except for Certificates to Assist with Self Administered Medications. B. In an interview with the administrator on 03/07/14 at 11:00 am, the administrator acknowledged he did not have any of the required records for his staff. C. In an interview with Caregiver #12 on	A 017	FACILITY STAFF HAS BEEN COMPLETED THE ORIENTATION AND ALL TRAINING REQUIRED BY 7NMAC 8.2.17 EXCEPT SAFE AND FOOD HANDLING PRACTICE C (3) WICH ALL FACILITY STAFF HAVE SCHEDULE TRAINING DATE ON MAY 29TH 2014 AT 1025 BROADWAY BLVD SE ALBUQUERQUE NEW MEXICO FROM 1:00 PM TO 4:00 PM WITH THE ENVIRONMENT HEALTH TRAINER MRS. ELIZABETH EASTMENT THAT SHE CAN BE REACHED AT 505-768-2638 FACILITY HAS AN ORGANIZED PERSONNEL FILE WITH ALL	5/5/14

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A 017	Continued From page 2 03/19/14 at 3:44 pm, the Caregiver confirmed she had not received training by the facility. D. In an interview with Caregiver #11 on 03/20/14 at 6:55 am, the Caregiver confirmed she had not received training by the facility.	A 017	ORIENTATION AND TRANING DOCOMENTATION WITH EMPLOYEES NAMES AND DATES OF COMPLETED TRAININGS AND FOR NEXT TRAININGS DUE DATES AS WELL. FACILITY WILL FOLLOW UP THIS RULE AND WILL BE DOCUMENTED	5/5/14
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated	A 020		

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A 020	Continued From page 3 if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following:	A 020		

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A 020	Continued From page 4 (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the	A 020		

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A 020	Continued From page 5 resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010]	A 020		

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A 020	Continued From page 6 This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.20 ADMISSIONS AND DISCHARGE: A. (1 through 14) Based on record review and interview, the facility failed to have admission agreements for 6 (#3 through #8) of the 8 (#1 through #8) residents' records reviewed at the facility. This widespread deficient practice could lead to the residents and surrogate decision makers to not understand or know all aspects of this rule which includes possibly not knowing what services will be provided, which could affect the health and safety of these 6 residents (#3, #4, #5, #7, and #8) in the facility and the 1 former resident (#6). The findings are: A. Review of records for residents #3 through #8 revealed no admission agreements on file. B. In an interview with the administrator on 03/07/14 at 11:00 am, the administrator acknowledged admissions agreement records for were not available for residents' #3 through #8. Refer to 7.8.2.20 B. (8) Based on record review, interview, and observation, the facility failed to not admit 1 (#8) of 8 residents (#1 through #8) who was determined by medical professionals as not appropriate for a Lower Level of Care. This isolated deficient practice could lead to harm due the facility admitting a resident that the facility is not allowed or qualified to provide care too. The findings are: A. Review of records for Resident #8 revealed he	A 020	EVERY RESIDENT HAS NOW THEIR ADMISSION AGREEMENT ON THEIR RESIDENT'S FILE THE ADMINISTRATOR NOW KEEP A ORGANIZED RESIDENT FILE FOLLOWING THE RULE 7NMAC 8.2.20 A (1 to 14).	5/5/14

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A 020	Continued From page 7 was discharged from a Behavioral Health Care Facility on 03/13/14. The latest Psychiatric Progress Note from the Behavioral Health Care Facility dated 03/10/14 revealed an "Impression" of Dementia with Behavior Disturbances, Depression, and Delirium and stated, "The patient is not psychologically appropriate for a lower level of care." B. In a tour of the facility on 03/19/14 at 7:25 am, Resident #8 wandered into the room of Residents #2 and #5 while the two female residents were still sleeping and he wandered around the room for 2.5 minutes and the only Caregiver on duty was never present or aware Resident #8 was in the room of Residents #2 and #5. C. In a tour of the facility on 03/19/14 at 3:44 pm, Resident #8 was observed lying on the bed in the private room of Resident #4. Caregiver #14 was trying to get resident #8 to get out of the bed of Resident #4. Resident #7 was agitated, combative, and refusing to get out of the bed and leave the private room of Resident #4. The Administrative Assistant entered the room at 3:46 pm to assist Caregiver #14. The Administrative Assistant was seen escorting Resident #8 out of the private room of Resident #4, down the hallway to Resident #8's own room. Resident #8 continued to be agitated, combative, and was trying to push the Administrative Assistant away. D. In a tour of the facility on 03/20/14 at 7:00 am, the broken remains of a 1 foot by 4 foot mirror were observed setting on a table in a room not in use, but unlocked. E. In an interview with Caregiver #12 on 03/20/14 at 7:00 am, the Caregiver acknowledged that Resident #8 had been violent and broke the	A 020	FACILITY HIRED A RN TO BE DO ALL RESIDENT ASSESSMENTS PRIOR TO MOVED IN TO THE FACILITY RN WILL BE CHECKING FOR A LEVEL OF CARE ON ALL ASSESSMENTS PRIOR TO MOVED IN TO THE FACILITY FACILITY HAD A CONFERENCE MEETING TO DISCUSS ALL RESIDENT #8's BEHAVIORS DOCTOR ORDERED WAS RESIDENT #8 NEED TO BE TRANSFER TO THE UNIVERSITY HOSPITAL FOR AN EVALUATION	

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A 020	Continued From page 8 mirror. F. At the exit Interview on 03/20/14 at 4:30 pm, the Administrative Assistant did not deny resident #8 was not appropriate for admissions to the facility.	A 020	RESIDENT #8 WAS TRANSFERRED TO THE UNIVERSITY HOSPITAL ON 03/22/2014	
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary;	A 021		

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A 021	Continued From page 9 (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility;	A 021		

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A 021	Continued From page 10 (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010]	A 021		

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A 021	Continued From page 11 This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.21 A. Record contents. Based on record review and interview the facility failed to have resident records for 8 of 8 residents records (#1 through #8) at the facility. This widespread deficient practice could lead to all residents and surrogate decision makers to not know what services will be provided, which could affect the health and safety of residents in the facility. The findings are: A. Review of records for residents #1 through #8 revealed the following records were not available: 1. For Resident #1 there was no Resident Evaluation form, no Physical Examination report, no personal and demographic information, no entries by direct care staff, and no documentation providing a written account of any accidents, injuries, illnesses, medical and dental appointments. 2. For resident #2 there was no Resident Evaluation form, no Individual Service Plan, no Physical Examination report, no personal and demographic information, no entries by direct care staff, and no record providing a written account of any accidents, injuries, illnesses, medical and dental appointments. 3. For resident #3 there was no Admissions Agreement, no Resident Evaluation form, no Physical Examination report, no personal and demographic information, no entries by direct care staff, and no record providing a written account of any accidents, injuries, illnesses, medical and dental appointments. 4. For resident #4 there was no Admissions	A 021	RESIDENT RECORDS (#1 TROUGHT #8) AT THE FACILITY HAS BEEN UPDATED AND COMPLETED BY RULE 7NMAC 8.2.21 A. RECORD CONTENTS	5/5/14

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A 021	Continued From page 12 Agreement, no Resident Evaluation form, no Physical Examination report, no personal and demographic information, no entries by direct care staff, and no record providing a written account of any accidents, injuries, illnesses, medical and dental appointments. 5. For resident #5 there was no Admissions Agreement, no Individual Service Plan, no personal and demographic information, no entries by direct care staff, no record providing a written account of any accidents, injuries, illnesses, medical and dental appointments 6. Former Resident #6 revealed no Admissions Agreement, no Individual Service Plan, no Resident Evaluation form, no Physical Examination report, no personal and demographic information, no entries by direct care staff, no record providing a written account of any accidents, injuries, illnesses, medical and dental appointments, or completed and signed transfer forms from the accepting facility when the resident was transferred to another health care facility. 7. For resident #7 there was no Admissions Agreement, no Resident Evaluation form, no Physical Examination report, no personal and demographic information, no entries by direct care staff, no record providing a written account of any accidents, injuries, illnesses, medical and dental appointments. 8. For resident #8 there was no Admissions Agreement, no Individual Service Plan, no Resident Evaluation form, no Physical Examination report, no personal and demographic information, no entries by direct care staff, and no record providing a written account of any accidents, injuries, illnesses, medical and dental appointments. B. In an interview with the administrator on	A 021		

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	2200	A. BUILDING: _____ B. WING _____	C 03/20/2014

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A 021	Continued From page 13 03/07/14 at 11:00 am, the administrator acknowledged that some of residents #1 through #8 records were not available.	A 021		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions;	A 025		

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A 025	Continued From page 14 (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.25 RESIDENT EVALUATION: Based on record review and interview, the facility failed to have resident evaluations for 8 of 8 residents (#1 through #8) records reviewed at the facility. The widespread deficient practice could lead to all facility staff to not understand or know all aspects of the care needs of the residents which could affect the health and safety of all currently in the facility. The findings are: A. Review of records for residents #1 through #4,	A 025		

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A 025	Continued From page 15 former resident #6, and residents #7 and #8 revealed no evaluations. Review of the evaluation for Resident #5 revealed no evidence it had been reviewed by a licensed nurse. B. In an interview with the administrator on 03/07/14 at 11:00 am, the administrator acknowledged that residents #1 through #4, former resident #6, and residents #7 and #8 evaluation records were not available.	A 025	FACILITY HIRED A RN TO BE IN-CHARGE OF ALL RESIDENT EVALUATION BY RULE 7NMAC 7.8.2.25 THE ADMINISTRATOR NOW KEEP AN ORGANIZED RESIDENT FILE WITH RESIDENT EVALUATIONS COMPLETED BY RN	CF 21 5/19/14 5/21/14
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided;	A 026		

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A 026	Continued From page 16 (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.27 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.26 INDIVIDUAL SERVICE PLAN (ISP): Based on record review and interview, the facility failed to have resident Individual Service Plans (ISP) for 5 (#2 and #5 through #8) of 8 (#1 through #8) residents records reviewed at the facility. The widespread deficient practice could lead to all facility staff to not understand or know all aspects of the care needs of the residents and the caregivers' responsibility of care for the residents which could affect the health and safety of residents in the facility and the former resident. The findings are: A. Review of records for residents #2, and #5 through #8 revealed no ISPs. B. In an interview with the administrator on 03/07/14 at 11:00 am, the administrator acknowledged that residents #2, and #5 through #8 records were not available.	A 026	FACILITY HAS NOW FOR EVERY RESIDENT AN INDIVIDUAL SERVICE PLAN (ISP) ON RESIDENT FILE FACILITY MADE A COORDINATED PLAN OF CARE FOR EACH RESIDENT WITH THE FOLLOWING PEOPLE INVOLVED: NURSE, FACILITY STAFF, SOCIAL WORKER, FAMILY AND RESIDENT	5/21/14

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A 031	7 NMAC 8.2.31 Handling of Emergencies HANDLING OF EMERGENCIES: A. Upon admission, each resident or surrogate decision maker shall designate a primary care practitioner (PCP) to be called in case of a medical necessity. Each resident or representative shall 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, the PCP or a physician extender shall be notified by the facility. B. The facility shall have a first aid kit that contains at a minimum, gauze, adhesive tape, antiseptic ointment and bandages for emergencies. The first aid kit shall be kept in a designated, easily accessible place within the facility. C. An easily accessible and functional telephone shall be available in each facility for summoning help in case of an emergency. A pay telephone does not fulfill this requirement. D. A list of emergency numbers including: fire department, police department, ambulance services and poison control shall be posted near each public telephone in the facility. [7.8.2.31 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.31 HANDLING OF EMERGENCIES: A. Based on record review and interview the facility failed to have documentation of residents'	A 031		

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A 031	Continued From page 18 Primary Care Practioner (PCP) and concerned person to be called in case of an emergency for 8 of 8 (#1 through #8) residents records reviewed, and further failed to notify the PCP or Power of Attorney when former Resident #6 possibly needed medical attention. This widespread deficient practice could lead to the PCP and the concerned persons to not be called when there is a medical need and resulted in former Resident #6 receiving medical attention without the knowledge of the resident's PCP or the resident's Power of Attorney (POA). The findings are: A. Review of records for Residents #1 through #8 revealed no documentation who the PCP was or who the resident's concerned person was. B. For former Resident #6 there was no documentation of any notice of these 2 people being notified on 01/30/14 when the facility administrator arranged for Resident #6 to be transported to the hospital emergency room for non-emergency medical treatment. C. In an interview with the Administrator on 02/21/14 at 10:00 am, the Administrator acknowledged on 01/30/14 he called for former resident #6 to be transported to the hospital to have her feeding tube put back in place. He did not notify the family, the POA, or the Hospice agency. D. In an interview with the Hospice agency Social Worker on 03/05/14 at 3:04 pm, the Social Worker acknowledged the family had expressed they wanted former Resident #6 to continue to eat solid foods and not have the feeding tube anymore.	A 031	FACILITY WILL HAVE A COORDINATED PLAN OF CARE AS NEEDED IN ORDER TO KEEP A GOOD COMMUNICATION OF THE RESIDENT CARE. FACILITY HAS NOW A RESIDENT PCP INFORMATION AND THE RESIDENT DESIGNATED PERSON TO BE CALLED IN CASE OF EMERGENCY. 5/21/14 ADMINISTRATOR WILL KEEP OF ANY DOCUMENTATION WHEN FACILITY CONTACTED THE RESIDENT PCP OR FAMILY OR POA. ADMINISTRATOR NOTIFIED POA AND HOSPICE AGENCY BUT FAILED TO DOCUMENTED ON THE RESIDENT FILE. FACILITY WAS NOT AWARE OF THIS MATTER NOW FACILITY WILL HAVE MORE COMUNICATION WITH FAMILY, POA AND HOSPICE AGENCIES.	

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A 033	Continued From page 19	A 033		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services besed on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all	A 033		

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A 033	Continued From page 20 services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are	A 033		

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A 033	Continued From page 21 informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 033		

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A 033	Continued From page 22 Refer to 7.8.2.33 C. Based on observation and interview, the facility failed to post the resident rights in a conspicuous public place in the facility. This deficient practice could cause residents 7 of 7 (#1 through #5, #7, and #8) currently residing in the facility to not understand or know the resident rights. The findings are: A. In a tour of the facility on 02/20/14 at 8:00 am, no resident rights poster was observed anywhere in the facility. B. In an interview with caregiver #11 on 02/20/14 at 8:05 am, when asked about a resident rights poster, she pointed to an 8.5" by 11" resident rights brochure on the wall of the medication storage and office work area. This is not in a public place for residents to see. Refer to 7.8.2.33 D. (10) Based on observation and interview, the facility failed to prohibit the use of physical restraints for 2 (#3 and #7) of 7 residents (#1 through #5, #7, and #8). This pattern of deficient practice could lead to harm due to the facility admitting residents that require a higher level of care than the staff have knowledge of providing. This caused 2 residents to be physically restrained by staff who do not have appropriate knowledge to correctly administer physical restraints. The findings are: A. During tour of the facility on 02/20/14 at 8:40 am, Resident #3 was observed to be in his wheelchair with a gait belt restraining him in the wheelchair with the gait belt fastened in back where the resident could not remove the gait belt.	A 033	FACILITY HAS NOW A RESIDENT RIGHT POSTER ON THE WALL BY THE ENTRY OF THE HOUSE. FACILITY HAS NOT USE PHYSICAL RESTRAINTS ANY MORE. SPECIFIES ON EACH Resident Care of Plan FACILITY WILL NOT USE GAIT BELT RESTRAINING FOR THIS USE ANY MORE	4/15/14 4/25/14

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A 033	Continued From page 23 B. In an interview with Caregiver #11 on 02/20/14 at 8:40 am, the Caregiver acknowledged Resident #3 had to be restrained in his wheelchair because he forgets he can't stand and he will try to stand up and fall. C. During tour of the facility on 02/20/14 at 8:40 am, Resident #7 was observed to be in her wheelchair with a wheelchair seatbelt. The Resident hands were observed to have extreme tremors and she was not able to use her hands to accomplish any tasks. D. In an interview with Caregiver #11 on 02/20/14 at 8:40 am, the Caregiver stated Resident #7 was unable to use her hands to do anything and can't unbuckle the seat belt. Caregiver #11 further acknowledged Resident #7 will slide down and fall out of her wheelchair.	A 033	RESIDENT #3 PASSED AWAY RESIDENT #7 HAS NOT A WHEELCHAIR WITH A WHEELCHAIR SEAT BELT. FACILITY HAD ON 4/25/2014 A COORDINATED PLAN OF CARE WITH FACILITY STAFF, FAMILY, POA AND HOSPICE NURSE AND SOCIAL WORKER, RESIDENT #7 NOW HAS A NEW FURNITURE PROVIDED BY HOSPICE: LOW HOSPITAL BED AND A RECLINED WHEELCHAIR WITH LAB BODY RESIDENT #7 WILL ROTATE FROM BED TO RECLINER CHAIR EVERY 45MIN. BY FACILITY STAFF TO AVOID BODY SORES AS TODAY SATE HAS 0 BODY SORES.	
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or	A 034		

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A 034	Continued From page 24 In a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose;	A 034		

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	2200	A. BUILDING: _____ B. WING _____	C 03/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CIELOS ABIERTOS ASSISTED LIVING	3111 TOREADOR NE ALBUQUERQUE, NM 87111

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A 034	Continued From page 25 (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (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 shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be 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. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC	A 034		

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A 034	Continued From page 26 and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.34 A. (1) Based on observation and interview, the facility failed to have medications for residents stored in a locked compartment or in a locked room for all 7 residents (#1 through #5, #7, and #8) currently residing in the facility. This widespread deficient practice could lead to harm due to the facility allowing the medications to be accessed by residents in the facility. The findings are: A. During tour of the facility on 02/20/14 at 8:15 am, Caregiver #11 was observed removing a bubble pack of medications from an unlocked cabinet and removing one pill and then putting the remainder of the bubble pack into the tray identified for resident #4. The cabinet was observed to have no locking mechanism. Caregiver proceeded to the room occupied by resident #4 and left the medication cabinet unattended. B. In an interview with Caregiver #11 on 02/20/14 at 8:20 am, the Caregiver acknowledged the cabinet was used for medications received before the facility runs out of the medication. C. During tour of the facility on 03/07/14 at 9:38 am, Caregiver #11 was observed leaving the room where the currently used mediations cabinet is located. The cabinet was left unlocked. The locked narcotics box was in this cabinet and was easily removable. The keys to the	A 034	FACILITY IMPLEMENTED A NEW SYSTEM TO MAKE SURE ALL MEDICATIONS ARE LOCKED AND SECURED, ALSO ALL FACILITY STAFF WAS RETRAINED ON HOW TO PASS MEDICATIONS, FACILITY KEPT ALL TRAINING DOCUMENTATION ON PERSONNEL FILE WITH DATES OF COMPLETED TRAININGS AND NEXT DUE DATES FOR NEXT TRAININGS. CAREGIVER #11 WAS RETRAINED ON ASSISTING WITH MEDICATION COURSE ESPECIALLY ON NEVER LEFT CABINET UNATTENDED, FACILITY HAS NOW A NEW SECURED CABINET WITH LOCKING MECHANISM. CAREGIVER #11 RECEIVED A WARNING and SITE WAS TRAINED ON: -THE MEDICATION CABINET MUST	5-1-14

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A 034	Continued From page 27 medication cabinet and to the narcotics box were observed lying on top of the medication cabinet. The Administrative Assistant (AA #01) was in the room looking at the facility's Medication Administration Record (MAR) binder. D. In an interview with the AA #01 on 03/07/14 at 9:38 am, the AA #01 said, "I help [Administrators name] with the MAR's [Medication Administration Records] and paperwork." E. In an observation on 03/07/14 at 9:43 am, the AA #01 leaves the room with medication cabinet still unlocked with the keys to the medication cabinet and to the narcotics box still lying on top of the medication cabinet. F. In an interview with the AA #01 and Caregiver #11 on 03/07/14 at 9:50 am, they acknowledged the medication was unlocked and the keys to the cabinet and the narcotics box were lying loose on top of the medication cabinet. G. Tour of the facility on 03/19/14 at 7:25 am, the medication cabinet was again observed to be unlocked, unattended, and accessible to all residents in the facility. Three bottles of prescription Hydrocodone/APAP 5/325 tablets MFG and a blister pack of Oxycodone HCL 5 mg with 45 tablets were observed in the unlocked medication cabinet and not locked in the narcotics storage container. At 7:30 am, during the observation, Resident #7 who has a diagnosis that includes Dementia with Behavior Disturbances and Depression wandered into the room where the unlocked and unattended medication cabinet was located. Resident #7 wandered around the room for 2.5 minutes and the only Caregiver on duty was never present or aware the Resident was in the room with access	A 034	BE LOCKED ALL THE TIMES - NARCOTICS MEDICATION MUST KEEP WY TH DOBBLE LOCKED AA #01 WAS RETRAINED ON ASSISTING WITH MEDICATION COURSE - FACILITY HAD A MEETING ABOUT HOW IMPORTANT IS TO KEEP ALL MEDICATION SECURED ALSO WE COVERED THE RULES AND REGULATIONS ON MEDICATIONS. FACILITY HAD ALREADY A MEDICATION TRAINING FOR ALL FACILITY STAFF ALL ALL STAFF HAS A SUCCESSFULLY COMPLETED A STATE APPROVED ASSISTANCE WITH SELF-ADMINISTRATION OF medication training Program.	

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A 034	Continued From page 28 to the medications. H. In an interview with Caregiver #11 on 03/19/14 at 7:40 am, Caregiver #11 acknowledged the Hydrocodone and Oxycodone were not locked in the narcotics box and the medication cabinet was left unlocked. Refer 7.8.2.34 A. (10) Based on record review and interview the facility failed to have any records of medications destruction for discontinued medications by physician's orders or for discharged or deceased residents (#1 through #5 ,#7, and #8). This deficient practice reveals a pattern that has the potential for harm due to the possibility of medications to be improperly used by individuals the mediations are not prescribed for. The findings are: A. Review of facility records and the quarterly Consulting Pharmacist report revealed no records of medication destruction. B. In an interview with the administrator on 03/07/14 at 11:00 am, the administrator acknowledged there were no records of medication destruction.	A 034	CAREGIVER #11 WAS RETRAINED ON HOW TO KEEP SECURED NARCOTIC BOX. Facility has a dobble locked System for NArcotic Medication FACILITY HAS NOW AVAILABLE FORMS FOR RECORDS OF MEDICATIONS destruction For discontinued Medications by doctors OR For discharged or deceased residents 5/21/14 Facily has An Organized File to keep all medication destruction. all staff was trained about this	
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when	A 035		

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A 035	Continued From page 29 needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) madication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed	A 035		

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A 035	Continued From page 30 nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued;	A 035		

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A 035	Continued From page 31 (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the	A 035		

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A 035	Continued From page 32 pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC. [7.8.2.35 NMAC - Rp, 7.8.2.36 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.35 D. Based on record review and interview the facility failed to have licensed personnel administer medications to 3 of 7 Residents (#2, #3, and #5) observed that are unable to self administer and failed to have licensed personnel administer medications to 1 Resident (#7) that is capable of self administration of medication (#1 through #5, #7, and #8). This deficient practice reveals a pattern that could lead to causing harm due to not having Licensed Medical Personnel to assess the residents at the time of the medication administration. The findings are: A. In an interview with Caregiver #11 on 02/21/14 at 8:09 am, she acknowledged the medications for Residents #2, #3, and #5 are crushed up and mixed with liquid and fed to the residents. When Caregiver #11 was asked if any of these 3 Residents were able to take their medications on their own, the Caregiver replied, "No, they don't understand." When caregiver #11 was asked if	A 035	FACILITY HAD A COORDINATED PLAN OF CARE FOR ALL RESIDENT THAT ARE UNABLE TO SELF ADMINISTER MEDICATIONS. COORDINATED PLAN OF CARE WAS FOR RESIDENTS #2 and #3 Because Resident #5 Passed away. 5/21/14 Hospices RN's ARE Responsible to all medication administration.	

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A 035	Continued From page 33 these residents understand they are getting their medications administered, she replied, "No." B. In a tour of the facility on 03/18/14 at 4:15 pm, Caregiver #13 was observed feeding Resident #2 and Resident #5 from separate bowls with separate utensils. Neither resident was observed using thair hands or arms. Resident #7 was observed feeding herself, was able to get extra helpings on her own, would answer questions when asked, and would understand/follow instructions which demonstrates she is capable of self administration of medications. C. In a tour of the facility on 03/18/14 at 5:00 pm, Caregiver #13 was observed preparing 7 medications tablets in a cup for resident #7 and with her fingers placed one of the larger tablets on a tissue by the Resident's bed. Caregiver #13 then poured the remaining tablets in the mouth of Rasident #7, gave the Resident some water, and then picked up the remaining larger tablet with her fingers and place the tablet in the mouth of Resident #7 and gave more water. D. In a tour of the facility on 03/18/14 at 5:00 pm, Caregiver #13 was observed preparing 2 tablespoons of Lactulos and 2 tablespoons of Colace in syringes and inserting into the mouth of Resident #5 and discharging the syringes contents into the mouth of Resident #5. Resident #5 was observed moving her hands in motions that didn't have any purpose or control. E. Review of the New Mexico Board of Nursing Website License/Certificate look up page revealed that none of the facility caregivers were licensed to administer medications.	A 035	Facility INFORMED All FACILITY STAFF THAT THEY ONLY CAN PASS MEDICATION (SELF ADMINISTRATION) FACILITY NURSE WILL BE ABLE TO HELP HOSPICE NURSE on Medication administration Facility caregivers will not administra medications.	

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A 036	Continued From page 34	A 036		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from tha resident ' s physician for residents who have medically prescribed special	A 036		

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A 036	Continued From page 35 diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the	A 036		

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A 036	Continued From page 36 state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting	A 036		

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CIELOS ABIERTOS ASSISTED LIVING	3111 TOREADOR NE ALBUQUERQUE, NM 87111

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A 036	Continued From page 37 covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is	A 036		

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A 036	Continued From page 38 maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal	A 036		

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A 036	Continued From page 39 regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.36 A. (2) (a through e) Based on record review and interview the facility failed to have staff in-service training for the 5 of 5 Caregivers (#11 through #15) that prepare food for the 7 of 7 residents (#1 through #5, #7, and #8) that reside in the facility. This widespread deficient practice could lead to harm due to the facility not having properly trained staff prepare safe and sanitary foods. The findings are: A. Review of records for Caregivers (#11 through #15) revealed no documentation of training at orientation or in-service training for instruction in proper food storage; preparation and serving food; safety in food handling; appropriate personal hygiene; and infectious and communicable disease control. B. In an interview with Caregiver #11 on 03/19/14 at 8:40 am, Caregiver #11 acknowledged the facility had not provided any dietary or food handling training. Refer to 7.8.2.36 B. (1)	A 036	FACILITY STAFF HAS A SCHEDULE TRAINING DATE ON MAY 29th 2014 AT 1025 BROADWAY BLVD SE From 1:00 pm to 4:00 pm with the Environment Heath trainer Mrs. Elizabeth Eastment that	5/29/14

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A 036	Continued From page 40 Based on record review and interview the facility failed to have systematic record of all menus and revisions, including snacks, for a minimum of thirty calendar days for the 7 of 7 residents (#1 through #5, #7, and #8) residing in the facility. This widespread deficient practice could lead to affecting the health of all seven of the facility's residents by not receiving enough variety to maintain appetite and not enough variety in nutrition. The findings are: A. Record review of the facility menu at the facility revealed only two weeks of menus with no dates noted as to which week the two menus were for. The were no snacks observed on the menus and no substitutions documented. B. In an interview with Caregiver #13 on 03/18/14 at 4:15 pm, the Caregiver acknowledged there were only two weeks of menus in the facility with no dates noted as to which week the two menus were for and there were no snacks listed on the menus. She further acknowledged there are occasional substitutions, but they are not documented.	A 036	she can be reached at 505-768-2638 Facility also addressed all these concerns to All staff. Facility has a 30 days menu and has been corrected as well	
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded	A 042		

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A 042	Continued From page 41 furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.42 A. Based on observation an interview, the facility failed to maintain the facility's grounds in a safe, sanitary, and presentable condition for 7 of 7 residents (#1 through #5, #7, and #8). This widespread deficient practice could lead to harm for all of the facility residents due to the extreme possibility of disease carrying insect and rodent infestation and injury due to exposed nails and splintered lumber. The findings are: A. Tour of the facility on 03/07/14 at 9:30 am, the facility backyard was observed to have grown up in weeds with some as tall as 12 inches. There was an old vanity in pieces and used splintered lumber with exposed nails. B. In an interview with the Administrator on 03/07/14 at 10:00 am, the Administrator acknowledged the backyard needed cleaned up and maintained.	A 042	FACILITY BACK YARD WAS ALL CLEANED NOW.	4/15/14
A 049	7 NMAC 8.2.49 Doors DOORS: A. No door in any means of egress shall be locked against egress when the building is occupied.	A 049		

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A 049	Continued From page 42 (1) Exit doors may be provided with a night latch, dead bolt, or security chain, provided these devices are operable from the inside, by any occupant, without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed forty-eight (48) inches above the finished floor. (2) If locks are not readily operable by all occupants within the building, the locks must: 1) unlock upon activation of the fire detection or sprinkler system and 2) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written approval from the building, fire and licensing authorities having jurisdiction. B. All exit doors shall have a minimum width of thirty-six (36) inches. (1) Facilities with a capacity of ten (10) or more residents shall have exit doors leading to the outside of the facility that open outward. (2) Facilities with a capacity of fifty (50) or more residents must provide panic hardware at the exit doors. (3) No door or path of travel to a means of egress shall be less than twenty-eight (28) inches wide. C. All resident sleeping room doors must be at least one and three-quarters (1 3/4) inch solid core construction. D. Bathroom doors may be twenty-four (24) inches wide. Facilities with four (4) or more residents shall have at least one bathroom for every eight (8) residents with a door clearance of thirty-six (36) inches for access by persons with disabilities. E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside. F. All doors shall readily open from the inside. G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms.	A 049		

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A 049	Continued From page 43 [7.8.2.49 NMAC - Rp, 7.8.2.50 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.49 A. (1) Based on observation and interview, the facility failed to ensure the front door was operable by any occupant from the inside without the use of a key. This deficient practice could lead to harm for all residents (#1 through #5, #7, and #8) should there be an emergency evacuation needed. The findings are: A. Tour of the facility on 02/20/14 at 8:40 am, the front door was observed to be locked with a deadbolt lock that requires a key to unlock from the inside. B. In an interview with Caregiver #11 on 02/20/14 at 8:40 am, she acknowledged the door is kept locked and the Caregiver on duty has the only key. C. In an interview with Caregiver #15 on 03/20/14, she acknowledged the door is kept locked to keep Residents #7 and #8 from leaving and the Caregiver on duty has the only key.	A 049	FACILITY HAS NOW AN ELECTRONIC SYSTEM WITH A CODE TO THE open DOOR THIS SYSTEM IS CONNECTED TO THE ALARM SYSTEM OF THE HOUSE.	4/15/14
A 059	7 NMAC 8.2.59 Windows WINDOWS: A. Each sleeping room shall be provided with an exterior window. (1) The window shall be operable, screened and have a clear operable area of 5.7 square feet minimum; measured twenty (20) inches wide	A 059		

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A 059	Continued From page 44 minimum and measured twenty-four (24) inches high minimum. (2) The top of the window sill shall not be more than forty-four (44) inches above the finished floor. B. Screens shall be provided on all operable windows. C. The proposed use of bars, grilles, grates or similar devices shall be reviewed and approved by the licensing authority prior to installation. D. Sleeping rooms, living rooms, activity room areas and dining room areas shall have a window area of at least one tenth (1/10) of the floor area with a minimum of ten (10) square feet. [7.8.2.59 NMAC - Rp, 7.8.2.52 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.59 A. (1) Based on observation and interview, the facility failed to have window screens on the resident room windows for 7 of 7 residents (#1 through #5, #7, and #8). This widespread deficient practice could lead to harm for all of the facility residents due to the possibility of disease carrying insect infestation of the facility. The findings are: A. Tour of the grounds around the facility on 03/20/14 at 6:50 am, the windows to all 5 resident rooms were observed to not have screens. B. In an interview with the Administrative Assistant on 03/20/14 at 4:30 pm, the Administrative Assistant acknowledged the windows to resident rooms did not have screens.	A 059	FACILITY HAS NOW ALL SCREEN ON ALL WINDOWS OF THE HOUSE	4/15/14

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A 065	Continued From page 45	A 065		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.65 A. & B. Based on record review and interview, the facility failed to have monthly fire drills. This widespread deficient practice could lead to harm for all 7 (#1 through #5, #7, #8) of the facility residents due to the residents not knowing what to do if the fire alarm and/or smoke detection activates. The findings are: A. Review of records revealed one record of a fire drill dated 02/05/14 with no evacuation time noted; thus it was not a completed fire drill record.	A 065		

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A 065	Continued From page 46 There was no other documentation or evidence of fire drills being conducted. B. In an interview with Caregiver #13 on 03/18/14 at 8:35 am, Caregiver #13 was asked if there had been any fire drills when she has been working and she answered, "No." C. In an interview with Caregiver #12 on 03/19/14 at 3:44 pm, Caregiver #12 was asked if there had been any fire drills when she has been working and she answered, "No." D. In an interview with Caregiver #11 on 03/20/14 at 6:55 am, Caregiver #11 as asked if there had been any fire drills when she has been working and she answered, "No."	A 065	FACILITY HAD A MEETING WITH ALL FACILY STAFF PROVIDING a training about How the fire drill work and given them. dates when occurs. Facility will keep all Fire drills orgonized on a separted File. 4/15/14	
A 066	7 NMAC 8.2.66 Staff and Resident Fire and Safety Training STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff of the facility shall know the location and the proper use of fire extinguishers and the other procedures to be followed 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 shall 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 admitted to the facility shall be given an orientation tour of the facility to	A 066		

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A 066	Continued From page 47 include the location of the exits, fire extinguishers and telephones and shall be instructed in the actions to be taken in case of fire or other emergencies. D. Fire drill procedures. The facility must conduct at least one (1) fire drill each month. (1) Fire drills shall be held at different times of the day, evening and night. (2) The fire alarm system or detector system in the facility shall be used in the fire drills. During the night, the fire drill alarm may be silenced. (3) During the fire drills, emphasis shall be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall show the date and time of the drill, the number of personnel participating in the drill, any problem(s) noted during the drill and the evacuation time in total minutes. (5) The local fire department may be requested to supervise and participate in the fire drills. [7.8.2.66 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010] This REQUIREMENT Is not met as evidenced by: Refer to 7.8.2.66 A. B. C. Based on record review and interview the facility failed to instruct the staff regarding the proper use of fire extinguishers and other procedures to be followed in case of fire or emergencies, further failed to instruct the staff to detect and elimiate potential safety hazards and further failed to have any documenation of any inservices to staff for 5 of 5 Caregivers working at the facility (#11 through #15) and no records of fire and safety	A 066		

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A 066	Continued From page 48 orientation for all 7 residents (#1 through #5, #7, and #8). This widespread deficient practice could lead to the harm of all 7 of the facility residents due to the staff not being trained to prevent fire hazards or not knowing what to do in the event of a fire and residents not knowing what to do in case of a fire. The findings are: A. Review of facility records revealed no fire safety training records for Caregivers #11 through #15 or fire drill orientation for Residents #1 through #5, #7, and #8. B. In an interview with the administrator on 03/07/14 at 11:00 am, the administrator acknowledged he did not have any of fire safety training records for his Caregivers or Residents. C. In an interview with Caregiver #12 on 03/19/14 at 3:44 pm, Caregiver #12 confirmed she had not received any training by the facility, which would include fire safety training. D. In an interview with Caregiver #11 on 03/20/14 at 6:55 am, Caregiver #13 confirmed she had not received any training by the facility, which would include fire satety training.	A 066	Facility STILL working on training Facily staff on how to use of Fire Extinguisher will be done by the end of the May 2014.	5/31/14
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply.	A 068		

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CIELOS ABIERTOS ASSISTED LIVING	3111 TOREADOR NE ALBUQUERQUE, NM 87111

(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 068	Continued From page 49 (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (8) " Visit notes " means the documentation of	A 068		

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A 068	Continued From page 50 the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (g) a list of the current medications or biologicals	A 068		

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A 068	Continued From page 51 that the resident receives and who is authorized to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Excaptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with	A 068		

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A 068	Continued From page 52	A 068		

regard to decisions.
(5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC.
(6) The assisted living facility shall ensure the coordination of services with the hospice agency.
(a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs.
(b) The assisted living facility shall receive information and communication from the hospice staff at each visit.
(i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.).
(ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation.
(c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members.
(d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator.
(i) The process may be informal or formal depending on the nature of the issue.
(ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified.
E. Additional provisions. An assisted living facility

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NAME OF PRDVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 068	Continued From page 53 that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.68 B. Based on record review and interview the facility failed to have records of Hospice training for 5 of 5 Caregivers working at the facility (#11 through #15). This widespread deficient practice could lead to the harm of not receiving appropriate care for all 4 of facility residents #1, #3, #4, and #7 who have elected the Hospice option. The findings are: A. Review of facility records revealed no Hospice training records for staff #11 through #15 B. Review of facility records revealed residents #1, #3, #4, and #7 are receiving Hospice services.	A 068	Hospice already start with their training	

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A 068	Continued From page 54 C. In an interview with the administrator on 03/07/14 at 11:00 am, the administrator acknowledged he did not have any of the required training records for his staff. Refer to 7.8.2.68 C. Based on record review and interview the facility failed to meet the requirements for the Individual Service Plans (ISP) for Residents receiving Hospice (#1, #3, #4, & #7). This widespread deficient practice could lead to the harm of not receiving appropriate care for all 4 of facility residents #1, #3, #4, & #7 who have elected the Hospice option. The findings are: A. Review of records for Residents #1, #3, and #4 revealed no delineation of the role(s) of the hospice provider and the assisted living facility in the ISP (coordination of care). Review of records for Resident #7 revealed no ISP. B. In an interview with the administrator on 03/07/14 at 11:00 am, the administrator acknowledged the ISP's for Residents #1, #3, and #4 that were on file is all the facility had. C. In an interview with the Caregiver #11 on 03/19/14 at 7:46 am, she confirmed there was no ISP for resident #7. She further confirmed the services provided by the hospice agency were not on the ISP's for Residents #1, #3, and #4.	A 068	they must complete trainins by the end of the May 2014 Facility staff working with all ISP for each resident Facility will keep all ISP orgonized on the resident Chart	5/31/14 5/31/14
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule	A 070		

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A 070	Continued From page 55 are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: . . . D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved	A 070		

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A 070	Continued From page 56 media acceptable to the department of public safety and the federal bureau of investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. . . . E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The department and department of public safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico department of health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant , caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by department of public safety and the federal	A 070		

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A 070	Continued From page 57 bureau of investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview, the facility	A 070		

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A 070	Continued From page 58 failed to submit applications, copies of personal identification, signed authorization for release of information, three complete sets of readable fingerprint cards, and fees to the Caregiver Criminal History Screening Program (CCHSP) no later than 20 calendar days from the first day of employment for 5 of 5 (#11 through #15) caregivers and the Administrative Assistant (AA #01). The facility further failed to maintain any documentation relating to all employees evidencing compliance with these rules. This widespread deficient practice has the potential for a convicted felon to be employed at the facility and have physical access to all 7 (#1 through #5, #7, and #8) vulnerable adults in the facility. The findings are: A. Review of records for Caregivers #11 through #15 and AA #01 revealed no date of hire and there was no evidence of fingerprinting or proof that the required documents were sent to CCHSP at the time of the survey. B. In an interview with the administrator on 02/25/14 at 12:45 pm, he acknowledged not having any CCHSP documentation for caregivers #11 through #15 or AA #01. C. At the exit interview on 03/20/14 at 4:30 pm, the Administrative Assistant did not deny there was no evidence of fingerprinting or proof that the required documents and fees were sent to CCHSP for Caregivers #11 through #15 and himself. Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY	A 070	FACILY HAS NOW DATE OF HIRED. when they FACILITY STAFF HAS NOW FOR ALL STAFF Employment Clearance has been granted. 4/5/14 Facility has evidence of fingerprint or proof of required document and Fees for all staff. on organized file.	

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A 070	Continued From page 59 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry.	A 070		

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A 070	Continued From page 60 D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] Based on record review and interview, the facility	A 070		

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A 070	Continued From page 61 failed to make inquiry to the Employee Abuse Registry for 5 of 5 (#11 through #15) caregivers. This widespread deficient practice could lead to an employee being hired that is on the registry for abuse, neglect and/or exploitation and responsible for tha care of all 7 (#1 through #5, #7, and #8) vulnerable adults in the facility. The findings are: A. Review of records for caregivers #11 through #15 revealed no date of hire and no evidence of inquiry to the employee abuse registry for the 5 caregivers. B. In an interview with the administrator on 02/25/14 at 12:45 pm, he acknowledged not having documentation of inquiry to the Employee Abuse Registry for Caregivers #11 through #15. C. At the exit interview on 03/20/14 at 4:30 pm, the Administrative Assistant did not deny inquiry to the Employee Abuse Registry had not been completed for Caregivers #11 through #15.	A 070	Facility has now dates of hired and also evidence of inquiry to the employee abuse registry for all staff. Facility now has been completed for all caregivers. New employees will be doing same process at begining of employment. Thank you and God Bless you! Carlos Figueroa 505 203 8695.	4/15/14