Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2040	A. BUILDING _____ B. WING _____	09/03/2009

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A22	7 NMAC 8.2.22 Resident Records	A22	SEE PAGE 4 OF 5 AND PAGE 5OF 5 FOR CORRECTIVE ACTIONS	

7.8.2.22 RESIDENT RECORDS:

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

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

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

(a) An executed admission agreement.

(b) A completed resident assessment form.

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

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

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

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

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

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Monica Q Dorsey

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

TITLE: Director

(X6) DATE: 9-15-09

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A22	Continued From page 1	A22		

diet required.

(c) Any amendments to the admission agreement.

(d) The current completed resident assessment form.

(e) A completed and current individual service plan.

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

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

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

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

(j) Unless included in the admission

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A22	Continued From page 2	A22		

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

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

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

B. RESIDENT RECORDS, MAINTENANCE:

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

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

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

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

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

This REQUIREMENT is not met as evidenced by:
7.8.2.22 A.

Based on record review and interview the facility failed to ensure that medical records were complete for 3 of 5 resident records reviewed, (R1, R2,and R3,).

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A22	Continued From page 3 The findings are: A. During review of the medical record for resident R 1, R2, and R3, admission agreement was incomplete with no dates or signatures. 1. During review of medical record for resident R3 the resident assessment was incomplete and there was no evidence it was reviewed every 6 months. B. During an interview with the director on 09/02/09 7:00 PM, she acknowledged that the medical records were incomplete. 7.8.22. A.(3) (d) Based on record review and interview the facility failed to ensure that medical records were completed for 3 of 5 resident records reviewed. (R3) A. During review of medical record for resident R3, the resident assessment was incomplete with no signature and dates, and there was no evidence it was reviewed every 6 months. B. During an interview with the director on 09/02/07 at 7:30 PM, she acknowleded that the resident assessment did not have signatures or dates.	A22	A22 ~~A22~~ 7 NMAC 8.2.22 Residents Records ~~7 NMAC 8.2.22 Residents Records~~ Admission and medical records on resident R1, R2 and R3 were reviewed and all incomplete will be corrected signed and filed in the appropriate file belonging to that resident. On September 10th, 2009 meet with two appropriate healthcare professional to review, correct and sign all deficiencies in the August 2009, 6 month resident assessments as stated in the survey. All the other residents' files were reviewed for possible deficiencies. As a means of monitoring the corrections Genney's Senior care will put in place an updated assessment form which will be completed by a licensed healthcare professional and reviewed by the director to verify that all the required documentations are completed. All admission records will be updated, completed, reviewed and signed with the necessary addendum attached where appropriate by September 30th, 2009.	9-10-09 9-30-09
A66	7 NMAC 8.2.66 Related Regulations & Codes 7.8.2.66 RELATED REGULATIONS AND CODES: Adult residential care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows:	A66		

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A66	Continued From page 4 A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96). B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96). C. Adjudicatory Hearings, New Mexico Department of Health, 7 NMAC 1.2 (2-1-96). [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.66 NMAC - Rn, 7 NMAC 8.2.66, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to NMAC 7.1.13.10(D) Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Requirement to maintain documentation of Incident Management Training for all employees Based on record review and interview, the facility failed to ensure required documentation of training on abuse, neglect and misappropriation of property for 3 of 3 sampled staff records (S1, S2, and 3). The findings are: A. On 09/02/09 during review of the employee files, it was noted the required training documentation was not among administrative paperwork for Incident Management training B. During an interview on 09/02/09 at 8:00 PM with the director, she stated that she had not attended the training for 2009.	A66	A66 7 NMAC 8.2.66 Related Regulations & Codes To address the deficiency of the required Incident Management Training compliance the director and or all the staff will attend the training session given by the state or by a certified agency. Corrective action: One staff member will attend an Incident Management Training on or before September 30 and all staff will trained by October 3,2009. Monitor corrective action: All trained staff members will receive a certificate, which will be placed in the training files.	10-3-09