STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 Complaint investigations were completed for intakes NM00029321 and NM00029342 on 01/08/14 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint NM00029321 was substantiated with deficiencies cited as a result of this complaint. Complaint NM00029342 was unsubstantiated with no deficiencies cited as a result of this complaint.	A 000	Scanned 07-15-14 J.D. RECEIVED JUL 14 2014 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU	
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;	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 021	Continued From page 1 (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; (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	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 021	Continued From page 2	A 021		

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;
(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 021	Continued From page 3 (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.21 A. (7) Based on record review and interview, the facility failed to have the signature of the person making the entries on the "ADL [Activities of Daily Living] Record" for 1 (#21) of 4 resident charts reviewed (#21 through #24). This deficient practice could lead to inaccurate record keeping which could lead to resident(s) not receiving care when needed due to records documenting the care had already been performed by someone else. The findings are: A. Review of the facility's "ADL Record" for Resident # 21 revealed Caregiver # 50's and Caregiver # 51's initials in several of the spaces to show they provided that care activity for November, 2013. The handwriting did not match on several of the initialed spaces for these Caregivers and no other employee on the employee list has either of their initials. B. In an interview with Caregiver #50 on 12/20/13 at 8:45 am, this Caregiver was asked if it was her hand writing for her initials on the ADL Record for Resident # 21 on 11/20/13. She stated, "No." C. In an interview with Caregiver #51 on 12/20/13 at 9:45 am, this Caregiver	A 021	***Resident Records A 021 7NMAC 8.2.21 (7)*** *The facility manager will provide an Inservice to all staff on **July 10, 2014** to review appropriate documentation process. The Documentation Inservice will include the following points:* • *Caregiver staff must sign and initial each ADL record* • *The caregiver assisting the resident with ADL's will apply their initials to the appropriate space on the resident ADL record* • *No caregiver shall apply their initials on behalf of any other caregiver* • *The Facility Manager will monitor the ADL records weekly*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 021	Continued From page 4 acknowledged she had showered Resident #21 on 11/17/13 and 11/22/13 and it was her that initialed the ADL Record for those 2 days. She stated the initials for her on other care duties were not her writing because the Lead Caregivers will initial for them when the Caregivers tell them they are done with that care.	A 021		
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.	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 033	Continued From page 5 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 based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all 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	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 033	Continued From page 6 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 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	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 033	Continued From page 7 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: Refer to 7.8.2.33 D. (4) Based on observation and interview, the facility failed to provide a safe living environment for the facility residents by leaving doors to rooms with toxic materials unlocked and leaving oxygen bottles unsecured. This deficient practice could lead to harm to the resident(s) should resident(s) wander into rooms where the toxic materials and unsecured oxygen bottles are stored. This deficient practice could also lead to harm to the resident(s) should there be a fire in the hazardous area (laundry rooms) with fire doors not working properly to all 35 (#1 through 35) residents at the facility. The findings are: A. During a tour of the facility on 12/19/13 at 3:10 pm, the Southeast Laundry Room door latch was missing and the door was not closing fully. Laundry detergent with enzymes and bleach were in an unlocked cabinet in the laundry room. B. During a tour of the facility on 01/07/14 at 10:25 pm, the Southeast Laundry Room was again observed to have the door latch missing and the door was not closing fully. C. During a tour of the facility on 01/07/14 at 10:31 pm, 14 oxygen bottles were observed in the Southeast Handicap bathroom that were free standing and not in racks. The door was	A 033	***Resident Rights A 033 7NMAC 8.2.33 D (4)*** *A and B. Southeast Laundry Room Door* *The latch to the door has been replaced and the door repaired to close completely. Cleaning agents (laundry detergent and bleach) will be locked securely for safety.* *C. Southeast Handicap Bathroom* *The oxygen bottles, wheelchairs and other assorted items have been removed from this bathroom and repairs will be made to have the bathing unit functioning. Oxygen bottles that will be placed in racks for safety.* *D. Northeast Handicap Bathroom* *All assorted items (furniture, wheelchairs, walkers) are being moved to a storage facility off premises. The bathroom will be inspected and repaired accordingly to ensure it is functioning.* *E. Northeast Laundry Room* *The latch to the door has been replaced and the door repaired to close completely. Cleaning agents (bleach and refrigerant) will be locked appropriately for safety.* *F. Locks, chemicals, functioning bathroom* *All locks in the entire facility have been inspected and will be repaired to working condition by a professional locksmith on July 11, 2014. He will replace the door latches, adjust the doors, and apply locks to the cabinets.* *The facility has obtained the services of a handyman who will be on call for ongoing maintenance needs. A procedure will be put in place to monitor maintenance requests that will be addressed in timely manner.* *Caregivers will be given an inservice on 7/10/2014 regarding the proper storage of chemicals. The Facility Manager or designee will monitor compliance on an ongoing basis.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 033	Continued From page 8 unlocked and there were wheelchairs. and other assorted items stored in the bathroom which made it impossible for the bathing unit to be utilized. During this observation a long handled dust pan fell and almost hit this surveyor. D. During a tour of the facility on 01/07/14 at 10:40 pm, the Northeast Handicap bathroom was observed to have furniture, wheelchairs, walkers, and other assorted items stored in the room. The bathing unit could not possibly be utilized. E. During a tour of the facility on 01/07/14 at 10:50 pm, the Northeast Laundry Room door latch was missing and the door was not closing fully. There were 2 gallons of bleach in an unlocked cabinet and a bottle of refrigerant 22 setting out in the laundry room. F. In an interview with the Assistant Manager on 01/07/14 at 10:35 pm, the Assistant Manager acknowledged the door latches on both laundry rooms need replaced, the laundry cleaning chemicals need to be in the locked cabinets, and that neither of the handicap bathing units were usable and were being used for storage.	A 033		
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	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 034	Continued From page 9 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 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	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 034	Continued From page 10 self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (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	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 034	Continued From page 11 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 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. (7) Based on observation and interview, the facility failed to store medical gases (oxygen) in compliance with the National Fire and Protection Association (NFPA) 99 requirements. This deficient practice has the potential to effect the health and safety of all 35 (#1 through #35) residents at the facility should the pressurized bottles of oxygen tip over, become damaged, and start leaking. The findings are: A. During a tour of the facility on 01/07/14 at 10:31 pm, 14 oxygen bottles were observed in the Southeast Handicap bathroom that were free standing and not in racks where they could easily be tipped over causing damage to the pressurized oxygen bottle and possibly a leak. B. In an interview with the Assistant Manager on 01/07/14 at 10:35 pm, the Assistant Manager acknowledged the oxygen bottles need to be stored in racks to keep them from tipping over.	A 034	***Custodial Drug Permits A 034 7NMAC 8.2.34 (7)*** *A.Oxygen bottles have been removed from the bathroom and will be store in the resident room in racks as appropriate. Each resident DME supplier has been contacted to provide racks for their consumer's oxygen bottles. Caregivers will be given an inservice on **7/10/2014** on the proper storage of oxygen bottles. The Facility Manager or designee will monitor complience.*	
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	A 042		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 042	Continued From page 12 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 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 Based on observation and interview, the facility failed to maintain the 2 laundry rooms and 2 of the handicap bathing units in good repair. This deficient practice has the potential to effect the health and safety of all 35 (#1 through 35) residents in the facility due to 2 fire rated doors not closing and latching. The improper storage of items in 2 handicap bathrooms and the bathing units in those bathrooms not in working order render the 2 handicap bathrooms not usable for residents. The findings are: A. During a tour of the facility on 12/19/13 at 3:10 pm, the Southeast Laundry Room door latch was missing and the door was not closing fully. B. During a tour of the facility on 01/07/14 at 10:25 pm, the Southeast Laundry Room was again observed to have the door latch missing and the door was not closing fully.	A 042	***Maintenance of Building and Grounds A 042 7 NMAC 8.2.42*** *A and B. Southeast Laundry Room Door* *The latch to the door has been replaced and the door repaired to close completely.* *C. Southeast Handicap Bathroom* *The oxygen bottles, wheelchairs and other assorted items have been removed from this bathroom and repairs will be made to have the bathing unit functioning.* *D. Northeast Handicap Bathroom* *All assorted items (furniture, wheelchairs, walkers) are being moved to a storage facility off premises. The bathroom will be inspected and repaired accordingly to ensure it is functioning.* *E. Northeast Laundry Room* *The latch to the door has been replaced and the door repaired to close completely. Cleaning agents (bleach and refrigerant) will be locked appropriately for safety.* *F. Locks, chemicals, functioning bathroom* *All locks in the entire facility have been inspected and will be repaired to working condition by a professional locksmith on **July 11, 2014**. He will replace the door latches, adjust the doors, and apply locks to the cabinets.* *The facility has obtained the services of a handyman who will be on call for ongoing maintenance needs. A procedure will be put in place to monitor maintenance requests that will be addressed in timely manner.* *Caregivers will be given an inservice on **7/10/2014** regarding the proper storage of chemicals. The Facility Manager or designee will monitor compliance on an ongoing basis.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 042	Continued From page 13 C. During a tour of the facility on 01/07/14 at 10:31 pm, 14 oxygen bottles were observed in the Southeast Handicap bathroom that were free standing and not in racks. There were wheelchairs and other assorted items stored in the bathroom which made it impossible for the bathing unit to be utilized; thus the bathing unit was not being maintained for use by the residents. D. During a tour of the facility on 01/07/14 at 10:40 pm, the Northeast Handicap bathroom was observed to have furniture, wheelchairs, walkers, and other assorted items stored in the room. The bathing unit could not possibly be utilized; thus the bathing unit was not being maintained for use by the residents. E. During a tour of the facility on 01/07/14 at 10:50 pm, the Northeast Laundry Room door latch was missing and the door was not closing fully. There were 2 gallons of bleach in an unlocked cabinet and a bottle of refrigerant 22 setting out in the laundry room. F. In an interview with the Assistant Manager on 01/07/14 at 10:35 pm, the Assistant Manager acknowledged the door latches on both laundry rooms need replaced, the laundry cleaning chemicals need to be in the locked cabinets, and that neither of the handicap bathing units were usable and were being used for storage.	A 042		
A 043	7 NMAC 8.2.43 Hazardous Areas HAZARDOUS AREAS: Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than one hundred (100) sq. ft.,	A 043		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 043	Continued From page 14 storage rooms more than fifty (50) sq. ft. but less than one hundred (100) sq. ft. not storing combustibles, storage rooms with more than one hundred (100) sq. ft. storing combustibles, chemical storage rooms with more than fifty (50) sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either: (1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter (3/4) hour rating; or (2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or (3) other hazardous areas shall be enclosed with walls with at least a twenty (20) minute fire rating and doors equivalent to one and three-quarter (1 3/4) inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. Boiler, furnace or fuel fired water heater rooms. For facilities with four (4) or more residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one (1) hour. Doors to these rooms shall be one and three-quarter (1-3/4) inch solid core. [7.8.2.43 NMAC - Rp, 7.8.2.44 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.43 A. (2) Based on observation and interview, the facility	A 043		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2252	A. BUILDING: _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAVENNA ASSISTED LIVING	3051 TWIN OAKS NW ALBUQUERQUE, NM 87120

(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 043	Continued From page 15 failed to maintain two fire rated doors in two hazardous areas within the facility by the doors not having a working latch. This deficient practice has the potential to effect the health and safety of all 35 (#1 through #35) residents in the facility if there is a fire in either of these hazardous areas. The findings are: A. During a tour of the facility on 12/19/13 at 3:10 pm, the Southeast Laundry Room fire rated door was missing the latch and the door was not closing fully. B. During a tour of the facility on 01/07/14 at 10:25 pm, the Southeast Laundry Room was again observed to have the fire rated door missing the latch and the door was not closing fully. C. During a tour of the facility on 01/07/14 at 10:50 pm, the Northeast Laundry Room fire rated door was missing the latch and the door was not closing fully. D. In an interview with the Assistant Manager on 01/07/14 at 10:35 pm, the Assistant Manager acknowledged the door latches on both laundry rooms need replaced and the doors do not close all the way.	A 043	***Hazardous areas A 043 7 NMAC 8.2.43 (2)*** *A.& B. Southeast Laundry Room* *The latch to the door will be replaced and the door will be adjusted to close fully.* *C. North Laundry Room* *The latch to the door will be replaced and the door will be adjusted to close fully.* *All locks in the entire facility have been inspected and will be repaired to working condition by a professional locksmith on **July 11, 2014**. He will replace the door latches, adjust the doors, and apply locks to the cabinets.* *The facility has obtained the services of a handyman who will be on call for ongoing maintenance needs. A procedure will be put in place to monitor maintenance requests that will be addressed in timely manner.* *Caregivers will be given an inservice on **7/10/2014** regarding the proper storage of chemicals. The Facility Manager or designee will monitor compliance on an ongoing basis.*	