Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE 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 01	OPENING REMARKS A complaint investigation was completed on 8/26/2009 for NMAC 7.8.2-New Mexico Regulations Governing Adult Residential Care Facilities. Complaint Intake #NM00027244 was Unsubstantiated.	A 01		
A19	7 NMAC 8.2.19 Admissions 7.8.2.19 ADMISSIONS: No resident shall be admitted or retained who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. EXCEPTION: Maternity Shelters may accept residents below the age of eighteen (18). A. ADMISSION INTERVIEW. The Director of the facility or a designee responsible for admission and retention decisions, shall meet with the resident or the resident's agent or guardian, if the resident lacks decision-making capacity, and shall provide the resident with: (1) The facility's program narrative. (2) The facility's rules. (3) The facility's admission agreement, including costs and charges, refund provision, and contract termination policies. (4) The facility's bed hold policy. (5) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (6) A written description of the legal rights of the residents translated into another language, if necessary. (7) The facility's staffing pattern. B. RESTRICTIONS ON ADMISSIONS: Adult residential care facilities shall not admit or retain individuals requiring continuous nursing	A19	ES Scanned 09-30-09	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Estephanie Petropoulos TITLE RN (X6) DATE 9/22/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE 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
A19	Continued From page 1	A19		

care. Conditions or circumstances that usually require continuous nursing care, may include, but not limited to the following:

(1) Ventilator dependency.

(2) Pressure sores where skin loss penetrates beyond the skin, and into deeper tissue or bone, which are classified as Stage III or IV.

(3) Intravenous therapy or injections directly into the vein.

(4) Airborne infectious disease, in a communicable state, including tuberculosis, but excluding infections such as the common cold.

(5) Any condition requiring either physical or chemical restraints.

(6) Nasogastric tubes / gastric tubes.

(7) Tracheostomy care.

(8) Individuals presenting an imminent physical threat or danger to self or others.

(9) Individuals whose physician certifies that placement is no longer appropriate.

C. ADMISSION/RETENTION EXCEPTIONS: 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 to remain in the facility, and the facility wishes to re-admit or retain the resident, the facility must:

(1) Convene a team, comprised of:

(a) The facility director.

(b) The resident.

(c) The resident's agent, guardian or surrogate decision maker.

(d) The resident's advocate, such as the resident's case manager, Ombudsman, or social worker.

(e) If the treating physician is unable to meet with the team, then consultation and recommendations via phone is acceptable.

(f) Other appropriate health care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE 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
A19	Continued From page 2 professionals. (2) The team shall jointly determine if the resident should be admitted or allowed to remain in the facility. The team must approve a individual service plan that meets the specific needs of the resident. Such team approval must be in writing, signed and dated by all team members, must be maintained in the resident's record, and must: (a) Be based upon a individual service plan which identifies the resident's specific needs and addresses the manner that such needs will be met. (b) Ensure that the facility has and will maintain an evacuation rating of prompt or slow as determined by the Fire Safety Equivalency System (FSES). (c) Be based upon an assessment of the health, safety and well-being of the other facility residents. (d) Assess the impact that meeting the specific needs of the resident as set out in the individual service plan will have on the staff and on the other residents. (3) Notify the Licensing Authority within five (5) days of the completion of team approval. Such notification of team approval must be submitted in writing and include evidence of the team's consideration of items 7.8.2.19C2(a) through 7.8.2.19C2(d) above. [9-24-76, 7-11-86, 1-11-90, 4-7-97;7.8.2.19 NMAC - Rn. 7 NMAC 8.2.19, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.19 (C)- Retention Meeting Based on record review and interview, the facility failed to ensure that a resident who wishes to remain in the facility and requires a greater	A19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE 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
A19	Continued From page 3 degree of care than the facility would normally provide was granted a meeting to have those various needs considered as part of her care plan. The findings are: A. On 8/26/09 during review of the resident charts, it was noted in random resident chart #1 that the facility staff "was mean" to her. The chart did not contain any written facility investigation regarding that statement. B. On 8/26/09 during interview with the Administrator, she acknowledged awareness of the various requests made by the resident for "extras" such as "moving her bed" and more "help with her jewlery" along with indication that she was aware that due to the nature of her many requests, the resident could have interpreted the staff's reaction as "mean". She indicated awareness that it would be best to write a plan to address and document any concerns verbalized by the resident. She further acknowledged that copious documentation would be needed in the future regarding requests along with retention meeting with the care team to ensure that the facility would carry out plan with a time line to attempt to meet the resident's needs and document the progress of such attempts.	A19	A. Caregivers will document concerns from resident (chart #1) and actions taken to meet needs of the resident Resident will be retained based upon team approval Concerns expressed by other residents will be investigated within 24 hours. RN will initiate a team care meeting. B. Care team meeting to 1) modify Care Plan (chart #1) Facility will carry out plan of care & Care team will meet to discuss Retention. (chart #1) resident.	9/20/09 9/20/09 9/26/09 3/26/10
A35	7 NMAC 8.2.35 Custodial Drug Permit 7.8.2.35 CUSTODIAL DRUG PERMIT: Any facility licensed pursuant to these regulations who supervises the administration, self-administration, or safeguards medications for residents, must have a current custodial drug permit issued by the State Board of Pharmacy. EXCEPTION: Adult residential care facilities with one (1) resident are not required to have a custodial drug permit.	A35		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE 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
A35	Continued From page 4 A. PROCUREMENT, LABELING, AND STORAGE: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as required by the individual or specified by the individual's health care plan. The facility shall procure, label, and store medications for residents in a manner which shall be in compliance with state and federal laws. (1) All medications, including non-prescription drugs, will be stored in a locked compartment or in a locked room, as approved by the Board of Pharmacy, and the key will be in the care of the director or designee. (2) Internal medication must be kept separate from external medications. Drugs to be taken by mouth will be separated from all other dosage forms. (3) A separate locked compartment will be available in the refrigerator for those items labeled "keep in refrigerator." The refrigerator temperature will be kept between thirty-five (35) and forty-five (45) degrees Fahrenheit. A thermometer is required to be kept in the refrigerator. (4) All medications, including non-prescription medications, must be stored in separate compartments for each resident and all medications will be labeled with the residents' names. (5) A resident may be permitted to keep his/her own medication in a secure place in his/her room for self-administration if the physician's report has deemed it appropriate that the resident do so. (6) The facility may not require the resident to purchase prescriptions from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of	A35		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE 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
A35	Continued From page 5 inhalation therapy and for resuscitative purposes must comply with National Fire Protection Association (NFPA) 99. B. CONSULTING PHARMACIST: The facility shall maintain records demonstrating the consulting pharmacist provides the following: (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 must be reported to the Director of the facility and these irregularities must be acted upon. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation is 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. [7-1-64, 9-15-70, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.35 NMAC - Rn, 7 NMAC 8.2.35, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to NMAC 7.8.2.35(A)(1) - Drug Storage Based on observations and interviews, the facility failed to ensure that all medications were stored under locked conditions. The findings are: A. On 8/20/09 and again on 8/26/09 direct observations of the medication cabinet during the noon meal times, it was noted that the large glass sliding door was ajar and was unlocked. B. On 8/20/09 during interview with Staff #1, she	A35	A. med-assistants Received training on the importance of keeping the med-cabinet Locked - 9/20/09 RN + managers will monitor med cabinet daily to assure it is Locked. 9/20/09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE 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
A35	Continued From page 6 acknowledged that the medication cabinet was unlocked and again on 8/26/09 with Staff #2, she acknowledged that the medication cabinet was unlocked.	A35		
A36	7 NMAC 8.2.36 Medications 7.8.2.36 MEDICATIONS: Medications will be administered or staff assistance with medications provided and documented in accordance with state and federal laws. A. Licensed health care professionals are responsible for the administration of medications. B. Facility staff may assist a resident with medications if written consent by the resident is given to the director of the facility or their designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with medications. All staff assisting with medications shall have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications. C. No medications, including over the counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order by the physician and entry into the resident's record. D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and side-effects. E. Medications prescribed for one resident shall not be used for another resident. F. The facility shall have a Medication Administration Record (MAR) documenting	A36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE 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
A36	Continued From page 7 medications administered to residents, including over-the-counter medications. This documentation shall include: (1) Name of resident. (2) Date started. (3) Drug product name. (4) Dosage and form. (5) Strength of drug. (6) Route of administration (e.g. "by mouth"). (7) How often medication is to be taken. (8) Time taken and staff initials. (9) Dates when the medication is discontinued or changed. (10) The name and initials of all staff administering medications. G. Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting. H. PRN Medications: The use of PRN medications must be closely monitored and supervised by the facility and is based on one or more of the following conditions: (1) The resident is capable of determining when the medication is needed. (2) The resident's physician has provided detailed instructions to the pharmacy regarding the administering of the medication. The physicians instruction for a PRN medication shall include: (a) Symptoms that might indicate the use of the medication. (b) Exact dosage to be used. (c) The exact amount of medication to be used in a 24 hour period. (d) Directions as to what to do if the symptoms persist. (e) Possible interactions or side-effects that might occur.	A36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE 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
A36	Continued From page 8 (f) Manufacturer's label information for directions if deemed adequate by the physician. I. The facility must report all medication errors to the physician. J. The facility shall develop and follow a written policy for unused, outdated, or recalled medications being kept in the facility. [7-1-64, 9-15-70, 7019074, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.36 NMAC - Rn, 7 NMAC 8.2.36, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.36(B) - Administration of Medications - Medications will be administered and documented in accordance with state and federal laws. Based on observation and interview, the facility failed to ensure that evasive medication administration was conducted by licensed personnel for 2 facility resident (Resident #2 and Resident #3). The findings are: A. On 8/26/09 during observation of the afternoon medication pass, it was noted that Staff #3 who is unlicensed direct care staff trained only to assist with medications was preparing Rx 41605 - [rectal] suppositories to be applied at 1 suppository[sic] every eight hours for Resident #2. Subsequent to this observation, Staff #3 was observed along with Staff #4 to rectally administer this medication to Resident #2. B. On 8/26/09 during confidential resident interview #1, she reported that her insulin is being injected by varying direct care staff assigned to administer medications on any particular day. C. On 8/26/09 during interview with the Administrator and a active Registered Nurse, she	A36	A. Suppositories will only be administered by a licensed person (RN on staff or Hospice) med techs will call licensed person if a resident needs a suppository. 9/15/09 RN/administrator will reinforce this policy. 9/15/09 B. ALL residents receiving insulin are capable of self administration with some assistance from med tech.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE 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
A36	Continued From page 9 admitted that she was aware that unlicensed direct care staff who were trained only to assist wth medications were actually administering medications and conducting evasive medication administrations in the facility.	A36	B. RN will train staff (med-tech) on assisting resident to self inject. New residents who are insulin dependent must be able to self inject with assistance.	9/20/09
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: 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 7.1.9.8 - Caregivers Criminal History Screening Requirements (Effective January 1, 2006) - All applicants to whom an offer of employment is made must consent to a nationwide and statewide screening. Based on record review and interview, the facility failed to have documentation that direct care staff had been cleared through the New Mexico Caregivers' Criminal History Screening Program (CCHSP) for 2 employee files reviewed (Staff #5 and Staff #6). The findings are:	A66		9/20/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE 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
A66	Continued From page 10 A. On 8/26/09 during review of employee records, it was noted that Staff #5 with a hire date of 1/14/06 and Staff #6 with a hire date of 11/8/06 did not have on file documentation of CCHSP statewide screening addressed to the facility and conducted subsequent to hire within the required timeframes nor documentation of a full Caregivers Criminal History Screening (CCHSP) clearance addressed to the facility conducted subsequent to hire within the required timeframes. B. On 8/26/09 during interview with the Administrator, she acknowledged the issue. Refer to NMAC 7.1.12.8(a) Employee Abuse Registry (Effective January 1, 2006) - Care Provider requirement to inquire of registry prior to offer of employment to applicants. Based on record review and interview, the facility failed to maintain documentation that the Employee Abuse Registry (EAR) database was checked prior to offer of employment for 2 direct care staff employed after January 1, 2006 (Staff #5 and Staff #6). The findings are:	A66	A. Staff #5 + #6 have had their fingerprints mailed to CCHSP on All employee files were reviewed & employees who lacked documentation of CCHSP. have been done ALL New hires will be screened within the required time frame. RN/Administrator will assure New hires are screened	9/22/09 9/22/09 9/22/09 9/22/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE 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
A66	Continued From page 11 A. On 8/26/09 PM during review of the employee files it was noted that Staff #5 with a hire date of 1/14/06 and Staff #6 with a hire date of 11/8/06 did not have documentation of EAR search in their files on the database using the individual's identifying information. B. On 8/26/09 during interview with the Administrator, she acknowledged the issue.	A66	Employees #5 + #6 have documentation of EAR search in their files New employees will have documentation of EAR search in their files RN/Administrator will Review new employee files.	9/15/09 9/15/09 9/15/09