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	5855	A. BUILDING _____ B. WING _____	12/31/2007

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GRACE ADULT CARE HOME, INC	7100 CARRIAGE ROAD NE ALBUQUERQUE, NM 87109

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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 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.	A19	The following response and Plan of Correction in no way constitutes admission that Grace Adult Care Home believes were deficient practices but will respond appropriately to the deficiencies cited. **7.8.2. 19 Admissions19C (1-2) Admission/Retention Exceptions(1)Convene as a team (2)...Team approval to determine if the resident should be admitted or allowed to remain in the facility.** 1. (as per memo for DOH dated 9/24/07) A team meeting with the Hospice Clinician, facility owner and the resident's son is scheduled January 18, 2008 for R3. The responsibility of each entity(Facility and Hospice) will be clearly defined during the meeting and the individual service plan will state how the resident's needs will be met. The services that will be provided to R3 will not interfere with the care and services provided for the remaining residents in the facility. 2. A team meeting, as per memo from DOH dated 9/24/07, will take place prior to all new admits to Hospice. The team decision will be based on the residents current needs and if the facility can meet his/her needs. 3.The facility owner will convene a meeting with the Hospice Clinician, family member/resident, and himself prior to admitting a resident to Hospice.	

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A19	Continued From page 1 (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 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	A19	4. This deficient practice will be in compliance by January 18, 2008. **7.8.2 22 A Residents Records** 1. The daily direct care notes for R1, R2, & R3 now are signed with an authenticating signature by the staff person making the entry. 2. A "signature and initial" sheet has been placed in the front of each residents medical record that identifies each staff person with his/her typed name, original hand signature and initial. Staff have been instructed to sign their name immediately following their notation into the "direct care staff notebook" leaving no space between end of notation and staff signature. 3. The facility manager will review direct care notebook weekly and monitor for accuracy of staff signatures. 4. This deficient practice is now in compliance. **7.8.2.23A (11)(c.)(e-f) Reports and Records** 1. S11 will receive staff training on January 23, 2008, in the following areas: Fire Safety, confidentiality of records, residents rights, quality care based on resident's needs and incident reporting requirements. S12 and S13 will receive the above training along with safe food handling and infection control on January 23, 2008. All of the above inservice training will be repeated annually thereafter. Record of the training will be placed in the employee's file.	

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A19	Continued From page 2 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] [redacted] Based on records review and interview, the facility failed to maintain documentation that a team (comprised of facility director, resident, resident's agent, resident's advocate, and physician) was convened to jointly determine whether a resident requiring a greater degree of care than the facility would normally provide should be admitted in the facility, for 1 of 1 residents receiving hospice services as of 10/07 (100%). The findings are: A. During an interview with S11 on 12/31/07 at 11:00 a.m., S11 revealed that R3 was receiving	A19	2. All new hires will receive the required staff training (11)(c.)(e-f) at orientation, ongoing and annually. Documentation related to training received and date of each training will be in their employee file. 3. The facility manager will be responsible for scheduling the required staff training for all new hires within 30 days of employment, ongoing and annually as needed. 4. This deficient practice will be in compliance by January 31, 2008. **7.8.2. 26 A Resident Assessment** 1. Resident assessments (RA) for R1 and R2 are currently in compliance following their 6 month reassessment. The RA for R3 will be in compliance on January 18, following the Hospice/facility team meeting. 2. All new admissions will have their assessment completed within 5 days of admission, signed and dated by the staff person(nurse) filling out the RA. 3. The facility manager will notify the RA nurse on the date of each new resident admission, including Hospice residents, and also when there is a significant change in a residents condition. Each new assessment will be completed within 5 days of admission and when significant change occurs with a resident. 4. This practice is now in compliance. **7.8.2.27A Individual Service Plan** 1. The individual service plans for R2 and R3 are current as of January 18, 2008, due to the 6 month RA and development of the ISP. The ISP for R2 and R3 will be	

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A19	Continued From page 3 hospice services from Hospice de la Luz upon admission. B. Review of R3's resident records revealed that R3 was diagnosed with a terminal illness of dementia and was admitted into the facility on 10/12/07. R3's records contained a physician signed document dated 10/24/07 stating that she was appropriate for assisted living placement. However, there was no evidence that a team meeting was held to jointly determine whether R3 should be admitted into the facility. C. During an interview with S11 on 12/31/07 at 11:00 a.m., S11 acknowledged that the facility failed to convene a team to jointly determine whether R3 should be admitted into the facility.	A19	updated at the next 6 month evaluation in April 2008. 2. All new and remaining current resident service plans will be updated at their next 6 month RA. 3. The facility manager will monitor and notify the RA nurse on all new admissions and their ISP will be implemented within 14 days of admission. 4. This deficient practice is now in compliance. **7.8.2.27B (1-7) Service Plan must include the following:** 1. The Individual Service Plan for R1 and R2 will be updated following a meeting with hospice personnel and facility owner on January 18, 2008. The ISP will include what services will be provided, when/how often, outcome, etc. 2. All current resident service plans will be reviewed and noted with a written description of type of services provided, who, when, how, how often and where the services will be provided. All new residents ISP's will also be noted for the above requirements. 3. The RA nurse will monitor the residents ISP following the RA assessment and at each semi-annual review for all the required written components. 4. The deficient practice is now in compliance. **7.8.2.34 Residents Rights** 1. Two (2) Resident's Rights posters have been obtained and are now hanging in the front entry. 2. Residents and families are now aware	
A22	7 NMAC 8.2.22 RESIDENT RECORDS 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	A22		

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A22	Continued From page 4 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 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	A22	of the new posters. One poster is written in English and one poster is written Spanish. 3. The facility manager will check daily to see if the posters are available for family and resident viewing. Residents have been instructed that these posters are to remain hanging and not defaced or removed. 4. This deficient practice is now in compliance. **7.8.2.35 Custodial Drug Permit** **A(1) All meds stored in a locked room.** 1. The non-prescription medication for R1 has been placed in the individual residents medication basket and is now stored in the locked medication room. 2. Medications for all residents are stored in the locked medication room. Controlled meds are stored in a double locked unit. The key to the medication room is with the medication aide at all times. 3. The medication aide will monitor each shift to see that all medications are stored in the individual med basket of each resident and that the med room is locked at all times when not in use. 4. This deficient practice is now in compliance. **7.8.2. 36 C Medications** 1. Physician medications and treatment orders have been updated for R1, R2 and R3 and are available in the resident record. Per pharmacist recommendations, a sign out sheet is wrapped around each PRN (including controlled substances) medication card, with required	

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A22	Continued From page 5 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 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.	A22	documentation. The individual patients' narcotic record for R3 revealed that a controlled substance (Alprazolam) was signed out 5 times form 12/17/07 to 12/31/07. 2. All residents OTC and PRN medications (including controlled substances) will now be listed on MAR (medication administration record) and there is a current physicians order for each medication. The pharmacist will be notified of meeting regulatory compliance. 3. The facility manager will update each MAR at the end of every month and will include all OTC, PRN and controlled substances on the MAR. Current physicians orders will be checked for accuracy. 4. This deficient practice will be in compliance by January 31, 2008. **7.8.2.36F (1-10) MAR documentation** 1. The MAR (Medication Administration Record) for R1, R2 and R3 has been revised and now includes all OTC and PRN medications (including controlled substances). Staff initial each medication on the MAR when it is given. Staff names are listed to correspond to the initial on the staff person giving the medication. 2. All current residents will have a revised MAR in their file by January 31, 2008. Each MAR will include the name of the resident, date med was started, name of the medication, dosage and form of drug, strength of drug, route of administration, how often the medication is to be taken, time taken with staff initials, dates when the medication is discontinued or changed	

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A22	Continued From page 6 (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] [redacted] Based on records review and interview, the facility failed to ensure that entries in each resident ' s record were authenticated with the signature of the person making the entry for 3 of 3 sampled residents (100%). The findings are: A. Review of R1-R3's 12/07 daily direct care notes revealed no authenticating signatures of the persons making the entries. B. During an interview with S11 on 12/31/07 at 11:30 a.m., S11 acknowledged that the facility failed to ensure that direct care entries in R1-R3's resident records were authenticated with the signature of the person making the entries.	A22	and the name and initials of all staff assisting with medications. 3. The facility manager will print new MARs for each resident at the end of each month and will review each MAR for the required documentation. 4. This deficient practice will be in compliance by January 31, 2008. **7.8.2.37 Nutrition** **B. Copy of the weeks menu including snacks shall be posted...** 1. The current weeks menu is now posted. 2. The facility has a 3 week cycle menu and this weekly menu is rotated each week. 3. The facility manager will change the weekly menu each Sunday. Available snacks will be listed with the menu. 4. This deficient practice is now in compliance. **7.8.2.38 A. Food Management** 1. A five (5) day supply of canned food is now available for resident use. 2. The upcoming weeks menu will be reviewed before food is purchased. An adequate (5 day) supply of non-perishable food will be available.	
A23	7 NMAC 8.2.23 FAC. REPORTS,RECS.,P & PS & RULES 7.8.2.23 FACILITY REPORTS/RECORDS/POLICIES AND PROCEDURES/ AND RULES: A. REPORTS AND RECORDS: Each facility must keep the following reports, records, and policy and procedures on file at the facility	A23	3. The facility owner will check the 5 day supply of non-perishables and purchase food items as needed to meet the weekly menu. Snack items will also be available for residents. 4. This deficient practice will be in compliance by January 31, 2008.	

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A23	Continued From page 7 and make them available for review upon request of the Licensing Authority: (1) Fire Inspection Report. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have fire inspection reports. (2) Copy of the last survey conducted by the Licensing Authority, adverse actions or appeals thereto, and complaints. (3) Copy of the latest survey from Environmental Health Authority (if applicable) regarding kitchen and food management and, if private sewage disposal, and private waste disposal. EXCEPTIONS: Adult residential care facilities with three (3) or fewer residents are not required to be inspected by Environmental Health Authority. Facilities exempted by the Environmental Health Authority having jurisdiction, are not required to have a survey on file provided the exemption letter is on file. (4) TB test results of staff or any of their family members living in the facility. (5) One (1) month of menus planned and as served. (6) Record of fire drills: A record of all fire drills conducted at the facility. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to hold or record fire drills. (7) Written emergency plans and policies and procedures for medical emergencies, power failure, fire or natural disaster. Such plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes and refuge areas, responsibilities of personnel. (8) Licensing regulations: A copy of these regulations (Requirements for Adult Residential Care Facilities, 7.8.2 NMAC). (9) Custodial Drug Permit: A valid	A23	**7.8.2. 41A Building Construction.** 1. FSES (Fire Safety Evacuation System) forms are now available. FSES surveys will be conducted on each resident, results compiled and a facility-wide evacuation rating determined. 2. FSES scores will be completed, along with each monthly fire drill, for the next six months. All new admissions will be added to the equation and a facility wide rating will be determined. If the facility determines that the facility-wide score is less than prompt, action will be taken. 3. The facility manager will do a monthly FSES evaluation on each resident for the next 6 months. Facility wide score will be determined and recorded. These records will be kept in the file box with the other required state documents. 4. This deficient practice will be in compliance by January 31, 2008. **7.8.2.45 Heating Ventilation and Air Conditioning** 1. The fuel fired(gas) heater will be checked by January 31, 2008, and annually thereafter. 2. Recommendations (if applicable) will be acted upon. 3. The facility manager will notify the proper agency at the next renewal date. Record will be kept and available for review. 4. This deficient practice will be in compliance by January 31, 2008. **7.8.2.63D (2) Use of fire alarm system or detector system shall be used to conduct fire drill.**	

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A23	Continued From page 8 Custodial Drug Permit issued by the State Board of Pharmacy for those facilities licensed pursuant to these regulations. EXCEPTION: Adult residential care facilities with only one (1) resident are not required to have a custodial drug permit. (10) Vaccination of pets in the facility. (11) Staff training. (a) At orientation and on-going. (b) Appropriate to staff responsibilities. (Assistance with medications, dietary, environmental...) (c) Fire safety. (d) First aid. (e) Safe food handling practices. (f) Confidentiality of records and resident information. (g) Infection control (including universal precautions and linen handling). (h) Resident rights. (i) Providing Quality Resident care based on current resident need. (j) Reporting requirements for Abuse, Neglect or Exploitation. (12) A copy of License. (13) Employee personnel records, including an application for employment, TB certificates, training records, and personnel actions. (14) A copy of all WAIVERS/VARIANCES granted by the Licensing Authority. (15) A copy of the floor plans as approved for licensure. B. RULES: Prior to placement in or admission to a facility, a prospective resident or his/her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to but not limited to the following: (1) The use of tobacco and alcohol. (2) The use of the telephone. (3) Operation of television, radio, and	A23	1. The monthly fire drill records will now include the type of fire alarm system that is used for the fire drill. 2. All residents and staff will be notified prior to the use of the type of fire alarm system that will be used at the time of the fire drill. The local fire department will also be requested to supervise and participate in a fire drill. 3. The facility manager will conduct a fire drill monthly. Each monthly fire drill will be held at a different time of day, noting the type of fire system that was used and the results recorded on the fire drill sheet. 4. This deficient practice will be in compliance by January 31, 2008. **7.8.12 Employee Abuse Registry** 1. S11, S12 and S13 hired after 1/1/06 will have EAR (Employee Abuse Registry) checked by the owner, by January 31, 2008. 2. All pre-employment hires will have the EAR checked before date of hire. All inquires on new hires will have the results of the EAR in their personnel file. 3. The facility manager will do the pre-employment EAR inquiry at least 2 days before date of hire. 4. This deficient practice will be in compliance by January 31, 2008. **66 Related Regulations** **7.1.13.10F Incident Management posters.** 1. Incident Management Posters will be posted followng the IMS training that will be take place on January 23, 2008. 2. The IMT Posters will behung in a	

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(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
A23	Continued From page 9 stereo. (5) Use and safekeeping of personal property. (6) Meals. (7) Use of common areas. (8) Electric blankets or appliances used by residents. C. POLICIES AND PROCEDURES: All facilities shall have written policies and procedures covering the following areas: (1) Actions to be taken in case of accidents or emergencies, (e.g., gas leaks, injuries, transportation, medications,...). (2) Method of keeping informed when residents go outside of the facility (e.g., sign-out sheets). (3) The handling or resident's funds, if the facility provides such services. (4) Reporting of incidents, including abuse, neglect, and exploitation. (5) Handling of complaints. (6) Staff and resident fire and safety training. (7) Smoking. (8) The facility's bed hold policy. (9) Admission agreement. (10) Admission records. (11) Resident records. (12) Program Narrative. (13) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (14) Personnel policies. (15) Identifying and safeguarding resident possessions. (16) Securing medical assistance if a resident's own physician is not available. (17) NOTE FOR MATERNITY SHELTERS ONLY: In addition to the required	A23	strategic location for residents and family viewing. Residents/families will be given a copy of the IMT form for their reading. 3. The facility manager has scheduled the IMS training for January 23, 2008. and record of training will be placed in the employee file. The IMS training will be conducted annually thereafter for all staff. 4. This deficient practice will be in compliance by January 31, 2008.	

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	5855	A. BUILDING _____ B. WING _____	12/31/2007

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A23	Continued From page 10 policy and procedure topics listed above, Maternity Shelters shall have written policies and procedures regarding infant formula, feeding and equipment, and laundering of infant linen and diapers. (18) Staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles. (19) Staff training for employees who operate motor vehicles to transport residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.23 NMAC - Rn & A 7 NMAC 8.2.23, 8-31-00] [redacted] Based on records review and interview, the facility failed to conduct orientation and ongoing (annual) staff training in fire safety, safe food handling, confidentiality of records, infection control, resident's rights, quality care based on resident's needs, and incident reporting requirements for 3 of 3 total staff (100%). The findings are: A. Review of S11's personnel records revealed no documentation of ongoing training in the following topics: fire safety, confidentiality of records, resident's rights, quality care based on resident ' s needs, and incident reporting requirements. B. Review of S12's personnel records revealed no documentation of orientation training in the following topics: fire safety, safe food handling, confidentiality of records, infection control, resident ' s rights, quality care based on resident's needs, and incident reporting requirements.	A23		

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A23	Continued From page 11 C. Review of S13's personnel records revealed no documentation of orientation training in the following topics: fire safety, safe food handling, confidentiality of records, infection control, resident's rights, quality care based on resident's needs, and incident reporting requirements. D. During an interview with S11 on 12/31/07 at 12:30 p.m., S11 acknowledged that the facility failed to maintain records of orientation and ongoing (annual) training in the above topics for S11-S13.	A23		
A26	7 NMAC 8.2.26 RESIDENT ASSESSMENT 7.8.2.26 RESIDENT ASSESSMENT: A. A resident assessment to determine level of function and if the client's needs can be met by the facility. The initial assessment must be completed within five (5) days of admission and reviewed every six (6) months as part of the individual service plan. B. The resident assessment must establish a baseline in the resident's functional status and thereafter, identify resident changes through periodic reassessments. C. The resident assessment must be documented on a state approved resident assessment form and at a minimum include the following: (1) Cognitive patterns. (2) Communication/hearing patterns. (3) Vision patterns. (4) Physical functioning and structural problems. (5) Continence. (6) Psycho social well-being. (7) Mood and behavior patterns. (8) Activity pursuit patterns.	A26		

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(9) Disease diagnoses.
(10) Health conditions.
(11) Oral/nutritional status.
(12) Oral/dental status.
(13) Skin conditions.
(14) Medication use.
(15) Special treatment and procedures.

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

[redacted]

Based on records review and interview, the facility failed to complete initial assessments within five (5) days of admission for 3 of 3 sampled residents (100%). The findings are:

A. Review of R1's resident records revealed an admission date of 11/14/06 and an initial assessment dated 1/25/07.

B. Review of R2's resident records revealed an admission date of 5/19/07 and an initial assessment dated 7/16/07.

C. Review of R3's resident records revealed an admission date of 10/12/07 and an initial assessment dated 10/23/07.

D. During an interview with S11 on 12/31/07 at

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A26	Continued From page 13 11:30 a.m., S11 acknowledged that the facility failed to complete initial assessments on R2-R3 within five days of admission but the assessments are current as of the date of the survey.	A26		
A27	7 NMAC 8.2.27 INDIVIDUAL SERVICE PLAN 7.8.2.27 INDIVIDUAL SERVICE PLAN: A. An individual service plan, if prompted by the resident assessment, shall be developed and implemented within fourteen (14) days of admission, and must address those areas of need as identified in the resident assessment. The individual service plan must be reviewed by a licensed nurse at least every six (6) months, and revised as needed at the time of each assessment and consistently implemented in response to the resident's needs. B. The individual service plan must include the following: (1) Description of identified needs as noted in the resident assessment. (2) Written description of what services will be provided. (3) Who will provide the services. (4) When or how often the services will be provided. (5) How the services will be provided. (6) Where the services will be provided. (7) Goal and outcome of the service. (8) Documentation of the facility's determination that it is able to meet the needs of the resident.. [7-11-86, 1-11-90, 4-7-97; 7.8.2.27 NMAC - Rn, 7 NMAC.8.2.27, 8-31-00]	A27		

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A27	Continued From page 14 Based on records review and interview, the facility failed to develop and implement individual service plans (ISP's) within fourteen (14) days of admission for 2 of 3 sampled residents (66.6%). The findings are: A. Review of R1's resident records revealed an admission date of 11/14/06 and an initial ISP dated 5/7/07. B. Review of R2's resident records revealed an admission date of 5/19/07 and an initial ISP dated 7/16/07. C. During an interview with S11 on 12/31/07 at 11:30 a.m., S11 acknowledged that the facility failed to develop and implement initial ISP's for R2-R3 within fourteen days of admission but the ISPs are current as of the date of the survey. 7.8.2.27B. (1-7)	A27		
	Based on records review and interview, the facility failed to ensure that the individual service plans (ISPs) included the following: description of need, description of services provided, who will provide services, when/how often services will be provided, how services will be provided, where services will be provided, goal and outcome for 2 of 3 sampled residents (66.6%). The findings are: A. Review of R1's resident records revealed that R1 was receiving hospice services from Hospice de la Luz upon admission (11/14/06) for a terminal illness of prostrate cancer. R1's ISPs revealed no evidence that R1 was receiving hospice services and no evidence of the services provided, when/how often, outcome, etc..			

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A27	Continued From page 15 B. Review of R2's resident records revealed that R2 was receiving hospice services from Hospice de la Luz upon admission (5/19/07) for a terminal illness of dementia. R2 ' s ISPs revealed no evidence that R2 was receiving hospice services and no evidence of the services provided, when/how often, outcome, etc.. C. During an interview with S11 on 12/31/07 at 11:30 a.m., S11 acknowledged that the facility failed to ensure that hospice services were incorporated into R1-R2's ISPs.	A27		
A34	7 NMAC 8.2.34 RESIDENT RIGHTS 7.8.2.34 RESIDENT RIGHTS: All licensed facilities shall be aware of, protect, and enhance the rights of all residents. A. Prior to admission to a facility, a resident and/or legal representative shall be given a written description of the legal rights of the residents translated into another language, if necessary, to meet the residents understanding. B. If the resident is incapable of understanding his/her legal rights, and if he/she has no legal representative, then the licensee shall also give a written copy of the resident's legal rights to one of the following persons, in this order of priority: (1) the resident's spouse; (2) any of the resident's adult children; (3) either of the resident's parents; (4) any relative the resident has lived with for six or more months before admission; (5) a person who has been caring for, or paying benefits on behalf of the resident; (6) a placing agency; or (7) any other person, e.g., Ombudsman. C. These resident rights and the telephone number for the Ombudsman Program shall be	A34		

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A34	Continued From page 16	A34		

posted in a conspicuous place in the facility.

D. The facility, to protect resident rights must:

(1) Treat all residents with courtesy, respect, dignity and compassion.

(2) To the extent that resident required services fall within the scope of the facilities program, avoid discrimination in admission or services because of a resident's age, race, religion, physical or mental disability, or nationality.

(3) Furnish residents written information about all services provided by the facility and their costs, and advance written notice of any changes.

(4) Assure that residents have a safe and sanitary living environment.

(5) Provide humane care.

(6) Assure the resident's rights to privacy in medical care, including privacy during medical examinations, consultations and treatment; and protect the confidentiality of the resident medical records.

(7) Protect and assure the resident's 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.

(8) Assure the resident's right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and assure the resident's right's to receive visits from family, friends, lawyers, ombudsmen and community organizations.

(9) Prohibit the use of any and all physical and chemical restraints.

(10) Assure the residents are free from physical and emotional abuse and neglect.

(11) Assure that all residents are free

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A34	Continued From page 17 from financial abuse and exploitation by facility staff and/or management. (12) Consistent with the resident's health, abilities and security, assure the right of the resident to freely participate in religious, social, community and other activities; and freely associate with persons in and out of the facility. (13) Permit the residents to leave the facility freely and return without unreasonable restriction. (14) Prevent unjustified room transfers or discharge from this facility. (15) Use care and management practices that foster social interaction and avoid practices that unnecessarily result in social isolation. (16) Provide services consistent with informed consent. (17) Assure that all residents may voice grievances to the facility staff, public officials, the ombudsmen or any other person, without fear of reprisal or retaliation. (18) Promptly address and resolve resident complaints. (19) Foster resident participation and understanding in the development, review and modification of the resident's plan for care and treatment. (20) Respect a resident's choice of doctor, pharmacist and other health care provider. (21) Respect a resident's medical treatment decisions and advance directives, such as living wills and durable powers of attorney for health care. (22) Respect a resident's right to keep and use personal possessions without loss or damage. (23) Allow each resident to manage and control the resident's personal finances to the	A34		

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A34	Continued From page 18 extent that the resident is able, and provide to every resident a written record of all financial arrangements and transactions involving that resident's funds. (24) Allow residents to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management. (25) Require no resident to work for the facility. (26) Consult with the incapacitated resident regarding his/her care, regardless of the involvement of a guardian or surrogate decision maker. (27) Assure the involvement in, and consent of, an incapacitated resident's guardian or surrogate decision maker in the resident's care. E. The resident's rights shall not be restricted unless the resident agrees to such a restriction, and unless this restriction is described in detail in his/her individual service plan. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.34 NMAC - Rn, 7 NMAC 8.2.34, 8-31-00] [redacted] Based on observation and interview, the facility failed to post resident rights in a conspicuous public place in the facility. The findings are: A. Observation of material posted in the facility on 12/31/07 at 9:15 a.m. revealed no evidence of the Residents Rights poster. B. During an interview with S11 on 12/31/07 at 9:15 a.m., S11 acknowledged that the Resident ' s Rights poster was not posted in the facility.	A34		

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A35	Continued From page 19	A35		
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. 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'	A35		

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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 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]

[redacted] QUIREMENT is not met as evidenced [redacted] 7.8.2.35A.(1)

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A35	Continued From page 21 Based on observation the facility failed to store all medications, including non-prescription drugs, in a locked compartment or in a locked room for 1 of 3 sampled residents (33.3%). The findings are: A. Observation of the kitchen on 12/31/07 at 12:00 p.m., revealed a non-prescription medication with R1's name on it stored inside an open/unlocked kitchen cabinet.	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	A36		

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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 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.

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GRACE ADULT CARE HOME, INC	7100 CARRIAGE ROAD NE ALBUQUERQUE, NM 87109

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A36	Continued From page 23 (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. (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] [redacted] Based on records review, and interview, the facility started, discontinued, or changed medications (including OTC and PRN medications) without an order by the physician and entry into the resident ' s medication administration record (MAR) for 3 of 3 sampled residents (100%). The findings are: A. Review of consulting pharmacist records revealed that the consulting pharmacist last visited the facility on 12/12/07 and all medications and records were accurate and current. B. Observation of R1's secured medications on 12/31/07 at 12:00 p.m. revealed no physician ' s orders for many of the medications and no MAR entries for any PRN medications (including controlled substances). C. Observation of R2's secured medications on	A36		

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A36	Continued From page 24 12/31/07 at 12:00 p.m. revealed no physician's orders for many of the medications and no MAR entries for any PRN medications (including controlled substances). D. Observation of R2's secured medications on 12/31/07 at 12:00 p.m. revealed no physician's orders for many of the medications and no MAR entries for any PRN medications (including controlled substances). E. During an interview with S11 on 12/31/07 at 12:00 p.m., S11 revealed that the facility's practice was not to enter any PRN (as needed) medications, including controlled substances, on resident MARs. S11 acknowledged that the facility failed to ensure that physician's orders were on file prior to starting many of R1-R3's medications and failed to enter all PRN medications on R1-R3's MARs. [redacted] Based on records review and interview, the facility failed to accurately document medications administered to residents, including over-the-counter medications, on the Medication Administration Record (MAR) for 3 of 3 sampled residents (100%). The findings are: A. Review of R1's MAR revealed no entries for PRN (as needed) medications, including controlled substances, and no authenticating signatures (names) of staff initialing the MAR. B. Review of R2's MAR revealed no entries for PRN (as needed) medications, including controlled substances, and no authenticating signatures (names) of staff initialing the MAR.	A36		

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A36	Continued From page 25 C. Review of R3's MAR revealed no entries for PRN (as needed) medications, including controlled substances, and no authenticating signatures (names) of staff initialing the MAR. D. During an interview with S11 on 12/31/07 at 12:00 p.m., S11 revealed that the facility's practice was not to enter any PRN (as needed) medications, including controlled substances, on resident MARs. S11 acknowledged that the facility failed to accurately document medications administered to R1-R3 on their respective MARs and failed to ensure that that staff initialing the MARs provided corresponding authenticating signatures.	A36		
A37	7 NMAC 8.2.37 NUTRITION 7.8.2.37 NUTRITION: Each facility shall provide planned and nutritionally balanced meals in accordance with the recommended daily dietary allowance from the basic food groups to meet the nutritional needs of the age group. A. At least three (3) meals shall be served daily at regular times, or in accordance with the program narrative. (1) No more than a sixteen (16) hour span may exist between a substantial evening meal and breakfast. Snacks must be made available between meals and in the evening and must be listed on the daily menu. Vending machines shall not be considered a source of snacks. (2) A sufficient amount of time shall be allowed for meals to enable residents to eat at a leisurely pace and to socialize. B. A copy of the current week's menu, including snacks and therapeutic diets, shall be posted where residents and families can see it. Posted menus shall be followed and any	A37		

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substitution must be of equivalent nutritional value and recorded on the posted menu. Menus as served must be kept for thirty (30) days and be available to the public. Identical menus shall not be used on a one (1) week cycle basis.

C. Therapeutic diets and prescribed vitamin and mineral supplements shall be given and served only on the written orders of a physician. The physician's order shall become part of the resident's record and shall be updated as necessary.

D. The facility shall make every reasonable attempt to accommodate the resident's food preferences, and requests by the resident or the resident's representative to observe religious or cultural dietary practices.

E. Personnel handling food must be in good health , practice hygienic food-handling techniques, have good personal grooming, and be free from communicable disease transmissible via food.

F. Ensure the food is prepared by methods that will conserve nutritive value, enhance flavor, appearance, and is served at the proper temperature and in a form to meet individual needs.

G. All residents must be served in a dining room except for residents with a temporary illness, or documented specific personal preference.

H. If a resident consistently refuses to eat after encouragement, the resident shall be evaluated by an appropriate health professional. The resident shall be offered fluids more often during the time he/she is refusing to eat.
[7-1-64, 9-15-70, 5-26-72, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97;7.8.2.37 NMAC - Rn, 7 NMAC 8.2.37, 8-31-00]

[redacted] evidenced

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A37	Continued From page 27 [redacted] Based on observation and interview, the facility failed to post the current week's menu, including snacks, in a conspicuous public place in the facility. The findings are: A. Observation of material posted on the facility ' s refrigerator on 12/31/07 at 9:30 a.m. revealed no evidence of the current week ' s menu. B. During an interview with S11 on 12/31/07 at 9:30 a.m., S11 stated, "my mother [owner] took the current week's menu to the grocery store with her." S11 acknowledged that the facility failed to post the current week's menu, including snacks, in a conspicuous public place in the facility.	A37		
A38	7 NMAC 8.2.38 FOOD MANAGEMENT 7.8.2.38 FOOD MANAGEMENT: Each facility must store, prepare, distribute and serve food under sanitary conditions and in accordance with the New Mexico Environment Department Food Service and Processor Regulations, if applicable. A. Each facility shall ensure a minimum of a three (3) day supply of perishable and a five (5) day supply of non-perishable or canned food is provided for the residents. B. All milk, to include dry milk products, shall be Grade A pasteurized. C. Potentially hazardous food such as meat, milk, and custard shall be kept at 45 degrees F or below or at 140 degrees F or above. D. Each refrigerator and freezer shall be provided with an indicating thermometer accurate to plus or minus 3 degrees F, located in the warmest section of the refrigeration facility and must be of such type and so situated that the	A38		

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thermometer can be easily read. Thermostats shall not be relied upon to maintain temperatures at correct levels in the absence of thermometers. The temperature of the refrigerator shall be 35 degrees F- 45 degrees F. Freezer temperatures shall be maintained at 0 degrees F or below.

E. Refrigerators, freezers, kitchen area and food preparation areas shall be kept clean and sanitary at all times. Food stored in refrigerators/freezers shall be covered, dated, and labeled. Unused leftover food shall be discarded after three days.

F. Medication, biological, poisons, detergents, and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications may be stored in the refrigerator with food, if they are labeled and locked in a container marked specifically for medication.

G. Dishes, utensils, and preparation equipment shall be properly washed and stored to maintain sanitary conditions.

H. All garbage and rubbish shall be stored in containers which are waterproof, easily cleaned and have tight fitting lids. Food waste containers shall be kept in good repair, and shall be kept covered except during use.

[7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 4-7-97; 7.8.2.38 NMAC - Rn, 7 NMAC 8.2.38, 8-31-00]

[redacted]

Based on observation and interview, the facility failed to ensure that a minimum of a five (5) day supply of non-perishable or canned food is available for the residents. The findings are:

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A38	Continued From page 29 A. Observation of the interior kitchen cabinets on 12/31/07 at 10:30 a.m. revealed few non-perishable and canned food items. B. During an interview with S11 on 12/31/07 at 10:30 a.m., S11 stated, "my mother [owner] is currently grocery shopping." S11 acknowledged that the facility failed to ensure that a minimum of a five day supply of non-perishable or canned food was available to the residents at the time of the survey.	A38		
A41	7 NMAC 8.2.41 BUILDING CONSTRUCTION 7.8.2.41 BUILDING CONSTRUCTION: When construction of buildings, additions,or alterations to existing buildings are contemplated, plans, code analysis and specifications covering all portions of the work shall be submitted to the Licensing Authority for plan review and approval prior to beginning actual construction. When an addition or alteration is contemplated, plans for the entire facility must also be submitted. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to submit floor plans. A. Building construction and the fire resistance required shall be based upon the capacity of the facility and the residents ability to evacuate the building, in accordance with the Uniform Building Code and NFPA 101 (Life Safety Code). (1) Larger buildings, which are more difficult to evacuate, require more built-in fire protection than smaller buildings. Occupants who are more difficult to evacuate require more built in fire protection than occupants who are easy to evacuate. (2) Evacuation capability, in accordance with NFPA 101, Fire Safety Equivalency System	A41		

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(FSES), must be determined before proceeding to identify applicable building requirements. Evacuation capability is not determined on the basis of that resident who is least capable to evacuate, but rather for the entire facility.

(3) Facilities not capable of prompt evacuation may not house residents unless the building is constructed to provide protection to these residents. All facilities that are rated as impractical to evacuate shall be protected throughout by an automatic fire protection (sprinkler) system. Facilities that are rated impractical to evacuate and that do not comply with the more restrictive building standards may not continue to care for residents.

(4) NEWLY LICENSED AND/OR CONSTRUCTED ADULT RESIDENTIAL CARE FACILITIES: Shall be protected throughout by an approved, automatic fire protection (sprinkler) system. EXCEPTION 1: Sprinklers shall not be required in facilities serving eight (8) or fewer residents maintaining prompt evacuation capability.

(5) CURRENTLY LICENSED FACILITIES: Any facility currently licensed on the date these regulations are promulgated and which provides the services prescribed under these regulations, but fails to meet all building requirements, may be granted a variance to continue to be licensed provided:

(a) The facility was in compliance with codes and standards at the time of initial licensure.

(b) Variances granted will not create a hazard to the health, safety, or welfare of residents and staff.

(c) The facility maintains prompt evacuation capabilities.

B. Minimum construction requirements shall be a twenty (20) minute fire resistance rating for

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all bearing walls and partitions, floor construction, roofs, columns, beams, girders and trusses.

C. NUMBER OF STORIES: Facilities may be of any number of stories if they comply with Uniform Building Code and NFPA 101 (Life Safety Code), with respect to construction and ability of the residents to evacuate in a timely manner.

(1) One story buildings may be of Type V-(000) construction if all residents are capable of prompt evacuation.

(2) Two story buildings must be of at least one hour construction. Residents who are not capable of prompt evacuation may not be housed above the street-level unless the facility is protected by an approved automatic fire protection (sprinkler) system.

(3) Three stories or more require the building to be protected by an approved automatic fire protection (sprinkler) system.

D. ACCESS TO PERSONS WITH DISABILITIES: Consultation may be given to new facilities on access requirements upon submission of floor plans during the initial licensing process. With the exception of Adult Residential Care Facilities with three or fewer residents, accessibility to persons with disabilities must be provided in all facilities in accordance with New Mexico Building Code and the American Disabilities Act and shall, as a minimum, include the following:

(1) Main entry into the facility must provide wheelchair access.

(2) Building must allow access to main living area and dining area.

(3) At least one bedroom shall be provided a door clearance of thirty-four (34) inches (thirty six (36) inches is recommended) for wheelchair access.

(4) One toilet and bathing facility is

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A41	Continued From page 32 required a minimum door clearance of thirty-four (34) inches (thirty six (36) inches is recommended) for wheelchair access. This toilet and bathing area must provide a sixty (60) inch diameter clear space (turning radius for a wheelchair). (5) If ramps are provided to the building, a minimum slope of twelve (12)inches horizontal run for each one (1) inch of vertical rise is required. Ramps exceeding a six (6) inch rise shall be provided with handrails. (6) Landings at doorways must have a minimum five (5) foot by five (5) foot level area at the doorway to provide clear space for wheelchair maneuvering. E. PROHIBITION ON MOBILE HOMES: Trailers and mobile homes shall not be used for any part of any adult residential care facility caring for more than three (3) residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.41 NMAC - Rn, 7 NMAC 8.2.41, 8-31-00] [redacted] Based on interview, the non-sprinkled facility failed to ensure that it maintained a "prompt" evacuation capability rating by conducting individual Fire Safety Evaluation System (FSES) surveys on each of its residents, compiling the results, and determining the facility-wide evacuation capability. The findings are: A. During an interview with S11 on 12/31/07 at 10:30 a.m., S11 revealed that the facility, licensed for 8 residents, had a current census of 6 residents.	A41		

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A41	Continued From page 33 B. During an interview with S11 on 12/31/07 at 10:30 a.m., S11 acknowledged that the facility failed to ensure that it maintained a "prompt" evacuation capability rating by conducting FSES surveys on each resident, compiling the results, and obtaining a facility-wide evacuation rating.	A41		
A45	7 NMAC 8.2.45 HEATING, VENTILATION AND AIR-CONDITIONING 7.8.2.45 HEATING, VENTILATION AND AIR-CONDITIONING: A. Heating, air-conditioning, piping, boilers, and ventilation equipment must be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities must have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. B. The heating method used by the facility must provide a minimum temperature of seventy (70) degrees Fahrenheit in all rooms used by the residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device may be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances must be permanently anchored and kept away from flammables such as curtains, bedcoverings, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or danger from electrical shock. D. Fireplaces and open flame heating are not permitted to be utilized in sleeping rooms. E. Gas fired water heaters must not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms. F. A facility must be adequately ventilated at	A45		

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A45	Continued From page 34 all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means. G. All openings to the outside air used for ventilation must be screened for the control of insects and rodents. Screen doors must be equipped with self-closing devices. H. A facility must be provided with a system for maintaining residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard or danger from electrical shock. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7-1-64, 9-15-70 9-24-76, 7-11-86, 4-7-97;7.8.2.45 NMAC - Rn, 7 NMAC 8.2.45, 8-31-00] This REQUIREMENT is not [illegible] evidenced [illegible] 7.8.2.45. Based on interview, the facility failed to provide documentation that its fuel-fired (gas) heater had been checked, tested, and maintained annually by qualified personnel. The findings are: A. During an interview with S11 on 12/31/07 at 10:00 a.m., S11 acknowledged that the gas heater had not been inspected annually by qualified personnel.	A45		
A63	7 NMAC 8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING 7.8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff personnel of the facility must know the location of and be instructed in proper use of fire extinguishers and other procedures to	A63		

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be observed 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 must 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 must upon being accepted into the facility be given an orientation tour of the facility to include, but not be limited to, the location of the exits, fire extinguishers, and telephones, and shall be instructed in action to be taken in case of fire or other emergency.

D. Fire Drills: The facility must conduct at least one (1) fire drill each month:

(1) Fire drills must be held at different times of the day.

(2) The fire alarm system or detector system in the facility shall be used in the conduct of fire drills.

(3) In the conduct of fire drills, emphasis must be placed upon orderly evacuation under proper discipline rather than upon speed.

(4) A record of fire drills held must be maintained on file in the facility. Such record must show date and time of the drill, number of personnel participating in the drill, any problem noted during the drill and the evacuation time in total minutes.

(5) The local fire department should be requested to supervise and participate in fire drills.

[9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.63 NMAC - Rn, 7 NMAC 8.2.63, 8-31-00]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5855	A. BUILDING _____ B. WING _____	12/31/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ADULT CARE HOME, INC	7100 CARRIAGE ROAD NE ALBUQUERQUE, NM 87109

(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
A63	Continued From page 36 [redacted] is not met as evidenced [redacted] Based on records review and interview, the facility failed to use the fire alarm or detector system in the conduct of fire drills. The findings are: A. Review of fire drill records revealed no evidence that the fire alarm/detector system was used in the conduct of fire drills. B. During an interview with S11 on 12/31/07 at 10:00 a.m., S11 stated, "the fire alarm is not used during fire drills because it frightens the residents." S11 acknowledged that the facility failed to use the fire alarm/detector system in the conduct of fire drills.	A63		
A66	7 NMAC 8.2.66 RELATED REGULATIONS AND 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	A66		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5855	A. BUILDING _____ B. WING _____	12/31/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ADULT CARE HOME, INC	7100 CARRIAGE ROAD NE ALBUQUERQUE, NM 87109

(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 37 by: [redacted] Based on record review and interview, the facility failed to maintain records of pre-employment Employee Abuse Registry (EAR) inquiries for 3 of 3 sampled non-licensed/non-certified staff (100%) hired as of 1/1/06. The findings are: A. Review of S11's personnel records revealed a hire date of 6/28/06 but there was no evidence of a pre-employment EAR inquiry. B. Review of S12's personnel records revealed a hire date of 7/21/07 but there was no evidence of a pre-employment EAR inquiry. C. Review of S13's personnel records revealed a hire date of 7/19/07 but there was no evidence of a pre-employment EAR inquiry. D. During an interview with S11 on 12/31/07 at 12:30 p.m., S11 acknowledged that the facility failed to maintain records of pre-employment EAR inquiries on S11-S13. [redacted] Based on observation and interview, the facility failed to post two (2) or more Incident Management posters, furnished by the division (Division of Health Improvement), in a prominent public location. The findings are: A. Observation of material posted in the facility on 12/31/07 at 9:15 a.m. revealed no evidence of the Division of Health Improvement Incident Management posters.	A66		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5855	A. BUILDING _____ B. WING _____	12/31/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A66	Continued From page 38 B. During an interview with S11 on 12/31/07 at 9:15 a.m., S11 acknowledged that the Incident Management posters were not posted in the facility.	A66		