PRINTED: 10/27/2016
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Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2171	A. BUILDING: _____ B. WING: _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RETREAT (THE)	4075 JACKIE RD SE RIO RANCHO, NM 87124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A00	Initial Comments On 06/21/16 a Full-Onsite survey [redacted] was conducted for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Deficiencies were cited as result of the survey. [redacted].	A000	7.8.2.20 A(5)(10)(12)C The Retreat is committed to providing complete information to all on all our families and decision makers on the admission and discharge policies included in their admission agreement. The practices at The Retreat for refunds upon leaving or death have been consistent with the stated regulation but improvements to the language in the agreement have been made to clarify those points. All families have been provided options in pharmacy choices and the contract has been adjusted to reflect this practice. There has been an update to the admission agreements effective 11/1/16 to reflect a more transparent and clear understanding of the Facility policies that coincide with the regulations. The administrator will ensure compliance to the changes proposed. Specifically, to improve our admission agreement the following changes have been made to our admission process and our admission agreement:	
A020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident's surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC;	A020		11-1-16

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rena B Frost, PhD — TITLE: Administrator — (X5) DATE: 12/23/16

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A020	Continued From page 1 (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found *for* the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident *or* his *or* her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay *for* a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer *or* discharge is necessary *for* the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; *or* (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost *or* the material services provided; a new or amended admission agreement must be executed whenever services, costs *or* other material terms are changed; and (14) facilities representing their services as " specialized" must disclose evidence of staff specially training to prospective residents. B. Restrictions in admission. The facility shall not admit *or* retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions *or* circumstances that usually require	A020	1. A policy update was made to our admission agreement which included the following: a. A full printed restatement of the Regulations *for* Assisted Living, Admissions and Discharge section, 7 NMAC 8.2.20 will be provided as a part of the admission agreement of the facility with a signature of receipt by the decision makers at time of admission. This will ensure that all families and residents are aware of the full scope of provisions afforded them *for* admission and discharge rights from the facility. All new admissions as of 11/1/16 will receive this addition to the admission agreement and provide a signed receipt.	11-1-16

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A 020	Continued From page 2 continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in	A020	b. Existing residents will receive a letter from the administrator by 11/5/16 with a copy of the regulations for NMAC 8.2.20. This will assure that all families have received the information regarding their rights and responsibilities pertaining to Admission and Discharge to the facility. It will clarify for existing families the updated policy that coincides with the regulation on admissions, discharges, bed hold and refunds. The Administrator will ensure that all future admissions contracts have the updated language consistent with State regulations. c. The admission agreement of the	11-5-16

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A 020	Continued From page 3 writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident's file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010]	A020	Facility has been updated to include the specific language on refunds when a resident leaves the facility or dies and is consistent with the regulations cited in NMAC 8.2.20. The administrator is responsible for ongoing compliance of admission contracts. d. The admission agreement of the Facility has been updated to include the specific language on transfer and discharge with and without notice consistent with the regulations cited in NMAC 8.2.20. e. The admission agreement of the Facility has been updated to include when an emergency	

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A020	Continued From page 4 This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) (10) (12) C Based on record review and interview, the facility failed to ensure for 6 of 6 (R #s 1-6) residents whose Admission/Discharge Agreements were reviewed for compliance that: 1. The Admission/Discharge Agreement includes accurate and complete information as to when and with/without notice notice the agreement can be terminated and/or a resident can be discharged. 2. The Admission/Discharge Agreement includes the facilities refund policy in the event of a resident death. 3. That the Admission/Discharge Agreements clearly states that residents have the right to use the pharmacy of their choosing without any facility imposed conditions. This deficient practice has the potential for the residents to be at risk of: 1. Being misinformed regarding when a facility can/cannot terminate the Admission/Discharge Agreement with or without notice. 2. Monies paid to the facility not being correctly refunded to their estate after death. 3. Not being able to exercise their right to use the pharmacy of their choice. The findings are: A. Record review of R #1 Admission Agreement dated 10/22/15 revealed that it: 1. Does not state that a facility can terminate the agreement "If an appropriate placement has been found. 2. Does not state that the facility can	A020	transfer or discharge can take place consistent with the regulations cited in NMAC 8.2.20. F. The admission agreement of the Facility has been updated to reflect the resident's /decision maker's choice in pharmacy choice. The facility has in practice been using multiple pharmacies and has not restricted families of using pharmacies of choice to include mail order pharmacies. The language has been adjusted to coincide with the regulations in NMAC 8.2.20. g. The admission agreement of the Facility will reviewed by the Facilities general counsel by 11/15/16 with the language changes.	11/15/16

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A020	Continued From page 5 terminate the agreement "with" notice if: a. The facility ceases to operate or is no longer able to provide services to the resident. b. The resident's health has improved sufficiently and therefore no longer requires the services of the facility. 3. Incorrectly states that the facility can terminate the agreement "with" notice if: a. The transfer/discharge is necessary for the resident's welfare because the needs cannot be met by the facility. b. The resident's health has declined to the point of requiring services not rendered by the facility. c. The safety and/or welfare of other individuals in the facility would be endangered or compromised. 4. Does not include the facility's refund policy in case of resident death. 5. Incorrectly states that the resident has the right to use the pharmacy of their choice "as long as" the pharmacy meets the facilities packaging requirements and provides 24-hours delivery service. B. Record review of R #2's Admission Agreement dated 11/03//15 revealed that it: 1. Does not state that a facility can terminate the agreement "if an appropriate placement has been found. 2. Does not state that the facility can terminate the agreement "with" notice if: a. The facility ceases to operate or is no longer able to provide services to the resident. b. The resident's health has improved sufficiently and therefore no longer requires the services of the facility. 3. Incorrectly states that the facility can terminate the agreement "with" notice if: a. The transfer/discharge is necessary for	A020	A new annual copy of the admission agreement with all changes will be provided to all decision makers for review and new signatures January, 2017, for the coming year. The Administrator will be responsible for ensuring the new agreements are updated. 2. It is the practice of the facility to provide care coordination between hospice staff and the Facility prior to admission to hospice despite lack of documentation. Effective 7/1/16 the facility began using a form: "Care Coordination and Care Planning" which documents the interaction and participants of the care coordination meetings between outside services (hospice) and the facility. The form also provides for the documentation of the Team's assertion that the resident can receive appropriate services in the facility based on the new status of hospice. A physician's signature is also present as a member of the Team. This care coordination meeting takes place prior to admission of the resident to Hospice. The Director of Nursing will ensure on-going compliance for new form.	1-30-17 7-1-16

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A 020	Continued From page 6 the resident's welfare because the needs cannot be met by the facility. b. The resident's health has declined to the point of requiring services not rendered by the facility. c. The safety and/or welfare of other individuals in the facility would be endangered or compromised. 4. Does not include the facility's refund policy in case of resident death. 5. Incorrectly states that the resident has the right to use the pharmacy of their choice "as long as" the pharmacy meets the facilities packaging requirements and provides 24-hours delivery service. C. Record review of R #3's Admission Agreement dated 12/23/14 revealed that it: 1. Does not state that a facility can terminate the agreement "if" an appropriate placement has been found. 2. Does not state that the facility can terminate the agreement "with" notice if: a. The facility ceases to operate or is no longer able to provide services to the resident. b. The resident's health has improved sufficiently and therefore no longer requires the services of the facility. 3. Incorrectly states that the facility can terminate the agreement "with" notice if: a. The transfer/discharge is necessary for the resident's welfare because the needs cannot be met by the facility. b. The resident's health has declined to the point of requiring services not rendered by the facility. c. The safety and/or welfare of other individuals in the facility would be endangered or compromised. 4. Does not include the facility's refund policy	A 020		

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A020	Continued From page 7	A020		

in case of resident death.

5. Incorrectly states that the resident has the right to use the pharmacy of their choice "as long as" the pharmacy meets the facilities packaging requirements and provides 24-hours delivery service.

D. Record review of R #4's Admission Agreement dated 06/04/10 revealed that it:

1. Does not state that a facility can terminate the agreement "IF an appropriate placement has been found.

2. Does not state that the facility can terminate the agreement "with" notice if:

a. The facility ceases to operate or is no longer able to provide services to the resident.

b. The resident's health has improved sufficiently and therefore no longer requires the services of the facility.

3. Incorrectly states that the facility can terminate the agreement "with" notice if:

a. The transfer/discharge is necessary for the resident's welfare because the needs cannot be met by the facility.

b. The resident's health has declined to the point of requiring services not rendered by the facility.

c. The safety and/or welfare of other individuals in the facility would be endangered or compromised.

4. Does not include the facility's refund policy in case of resident death.

5. Incorrectly states that the resident has the right to use the pharmacy of their choice "as long as" the pharmacy meets the facilities packaging requirements and provides 24-hours delivery service.

E. Record review of R #5's Admission Agreement dated 12115115 revealed that it:

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A020	Continued From page 8 1. Does not state that a facility can terminate the agreement "if an appropriate placement has been found. 2. Does not state that the facility can terminate the agreement "with" notice if: a. The facility ceases to operate or is no longer able to provide services to the resident. b. The resident's health has improved sufficiently and therefore no longer requires the services of the facility. 3. Incorrectly states that the facility can terminate the agreement "with" notice if: a. The transfer/discharge is necessary for the resident's welfare because the needs cannot be met by the facility. b. The resident's health has declined to the point of requiring services not rendered by the facility. c. The safety and/or welfare of other individuals in the facility would be endangered or compromised. 4. Does not include the facility's refund policy in case of resident death. 5. Incorrectly states that the resident has the right to use the pharmacy of their choice "as long as" the pharmacy meets the facilities packaging requirements and provides 24-hours delivery service. F. Record review of R #6's Admission Agreement dated 08/26/12 revealed that it: 1. Does not state that a facility can terminate the agreement "if an appropriate placement has been found. 2. Does not state that the facility can terminate the agreement "with" notice if: a. The facility ceases to operate or is no longer able to provide services to the resident. b. The resident's health has improved sufficiently and therefore no longer requires the	A020		

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A020	Continued From page 9 services of the facility. 3. Incorrectly states that the facility can terminate the agreement "with" notice if: a. The transfer/discharge is necessary for the resident's welfare because the needs cannot be met by the facility. b. The resident's health has declined to the point of requiring services not rendered by the facility. c. The safety and/or welfare of other individuals in the facility would be endangered or compromised. 4. Does not include the facility's refund policy in case of resident death. 5. Incorrectly states that the resident has the right to use the pharmacy of their choice "as long as" the pharmacy meets the facilities packaging requirements and provides 24-hours delivery service. G. On 06/21/16 at 2:05 pm, during interview with the Director of Operations (DOO), he confirmed that the admission agreements for R #s 1-6 were not accurate and complete, did not contain the facility refund policy in case of death, and placed conditions on the residents right to use the pharmacy of their choosing. Based on record review and interview the facility failed to ensure that an Admission/Retention team meeting is convened prior to admitting/retaining residents on hospice who may require a higher level of care than the facility would normally provide, to determine if the facility is an appropriate placement for 4 of 4 (R #s 6-9) residents identified as receiving hospice services on the resident census, provided by the Administrator, on 06/14/16. This deficient practice has the potential to affect the health and	A020		

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A032	Continued From page 11 (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2 A, B 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13 7 W. & 8 B. (2) W. " Reportable incident " means possible	A032		

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A032	Continued From page 12 abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor ' s order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division ' s incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau ' s incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure that all incidents of suspected or known resident abuse, neglect, or unusual occurrence which has or could threaten the health, safety, or welfare of the residents, were reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. That an internal investigation was conducted within 5 business days and submitted to the Licensing Authority for 5 of 5 (R #s 1, 3, 4, 10 and 11) resident records reviewed for for	A032	7 NMAC 8.2.32 Upon clarification of the regulation at time of survey the Facility made the following changes to their reporting of incidents: 1. A policy was drafted that outlined the full regulation and the appropriate steps for staff to follow in identifying, reporting and investigating incidents. Although the facility had maintained a practice of incident reports, notification to physician and responsible parties, and providing investigation and follow-up to all incidents, the new policy clarifies the steps for nursing and administrative personnel in when to report any suspected cases or known incidents of resident abuse, neglect or exploitation, injuries of unknown origin and other events. The updated policy provides clear steps in utilizing the state's incident management system	

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	2171	A. BUILDING: _____ B. WING _____	C 06/17/2016

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A032	Continued From page 13 incident reporting compliance. This deficient practice has the potential for residents to be at risk of being abused, neglected, and/or not receiving needed medical care and services if incidents are not being reported as required. If the facility is not conducting internal investigations and submitting their findings to the Licensing Authority, then residents are at risk of continued suffering and further injury if there is no oversite of the care and services the facility is providing. The findings are: A. Record review of a facility incident report and incident report communication to the physician dated 01/09/16 revealed that a 2:30 am, R #10 was found on the floor with her head against her roommates night stand. R #10 stated she was pushed to the floor by her roommate. R #10 suffered a broken hip. There was no documentation available to indicate that the facility reported the incident to the Licensing Authority or submitted a 5-day follow-up investigation report. B. Record review of a facility incident/accident report dated 03/24/16 revealed that at 6:20 pm, a male resident was found naked in R #3's bed. R #3 was found to have a skin tear on her right (R) anterior (front) forearm. The incident was unwitnessed. There was no documentation available to indicate that the facility reported the incident to the Licensing Authority or submitted a 5-day follow-up in investigation report. C. Record review of a facility incident/accident report dated 04/13/16 and daily progress notes revealed that at 1:30 pm, R #11 was found to have 2 nail marks on her left (L) forearm, that looked to be several days old, scabbed-over and bruised. Cause of the injury was unknown.	A032	2. As of 6/21/16 all incidents that met the stated guidelines were reported within 24 hours and a follow up report was provided to the state within 5 days. There have been 5 incidents reported between 6/2016 and 10/2016. None of the reported incidents were identified as abuse. 3. All directors of the facility were updated to the new policy during the time survey was taking place. Administrative nurses were provided additional in-services on the updated policy on 8/4/2016. 4. An additional policy was developed for the specific incident of "Resident to Resident" incident. It mirrors the overall policy of reporting incidents identified in #1, but enhances steps for nursing to take in the evaluation process of identifying precursors and non-pharmacological steps to consider when investigating a resident to resident incident. All nurses will have completed their inservice on this additional nursing policy by 11/15/16. The Director of Nursing will be Ensure on going compliance.	6-21-16 8.4.16 11-15-16

1/18/17 - Per Phone Conversation with Lenn Enard 24hr. Admin

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A032	Continued From page 14 There was no documentation available to indicate that the facility reported the incident to the Licensing Authority or submitted a 5-day follow-up in investigation report. D. Record review of a facility incident/accident report dated 05/07/16 revealed that at 1:45 pm, an unwitnessed resident to resident verbal and physical altercation occurred between R #1 and R #10. When staff arrived after hearing R #1 yell "Help Me", R #10 was observed holding and pushing R #1 to the ground by holding her arms very tightly. R #1 was found to have mild bruising and a small skin tear to her R-front forearm. There was no documentation available to indicate that the facility reported the incident to the Licensing Authority or submitted a 5-day follow-up investigation report. E. Record review of the facility incident/accident report and daily progress note dated 05/24/16 revealed that at 7:15 am, R #4 was found to have an injury (laceration) of unknown origin on the L-side of her head, bruising was occurring, dried blood was observed and appeared to have been cleaned. Resident was not able to say how the injury occurred. There was no documentation available to indicate that the facility reported the incident to the Licensing Authority or submitted a 5-day follow-up in investigation report. F. On 06/21/16 at 12:35 pm, during interview with the Director of Nursing (DON) she confirmed that the facility did not report the incidents for R #s 1, 3, 4, 10, and 11 to the Licensing Authority and that the facility is not documenting any internal follow-up investigations or submitting them to the Licensing Authority within 5 days.	A032		

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A034	Continued From page 15	A034		
A034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate.	A034		

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A034	Continued From page 16 (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident's name; (d) the prescriber's name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician's order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to	A034		

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A034	Continued From page 18 contain cryogenic liquids to prevent injury to the skin. 2. * Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose. 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage. 5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [see also 4-3.1.1.2(a)7). 6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat. 7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage.	A034		

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A034	Continued From page 19 Exception: Shipping crates or storage cartons for cylinders. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use. 9. Containers shall not be stored in a tightly closed space such as a closet [see 8-2.1.2.3(c)]. Reference NFPA 99, 1999 Edition Section 8-3.1. 11.3 (Signs) Based on observation and interview the facility failed to ensure that: 1. Oxygen cylinder tanks were stored securely, protected from accidental damage or dislocation. 2. "Oxygen In Use" signs were posted outside the rooms. If an oxygen cylinder tank were to fall over damaging the valve, causing it to depressurize or if there are not warning signs informing there is "oxygen in use" the all 54 (R #s 1-54) residents identified on the resident census list provided by the administrator on 06/14/16 are at an increased risk of harm if a fire were to occur. The findings are: A. On 06/14/16 at 1:40 pm, during observation, no "Oxygen In Use" sign was observed outside rooms (Rm #s 3 and 13 in unit A) of residents who use oxygen. B. On 06/14/16 at 3:12 pm, during interview the Dietary/Housekeeping director confirmed that there were no "Oxygen in Use" signs posted outside Rm #s 3 and 13 of unit A of residents who use oxygen. C. On 06/15/16 at 3:02 pm, during observation, 1 small oxygen cylinder tank was observed to be unsecured in the Unit-B medication room.	A034	7 NMAC 8.2.34 Effective 6/15/16 while survey was still continuing all rooms and areas with oxygen were provided a "Oxygen in Use" sign correcting the deficiency immediately. The Facility procured additional signage for backup inventory and initiated the following procedure: 1. A nurse manager was assigned that on each Saturday of each week all oxygen in the Facility would be checked by a nurse for good working condition, signage, and appropriate storage of tanks and cylinders. 2. The facility does have a designated rack and storage area that is only for cylinder storage. It meets the requirements of the regulation. The identified cylinder was replaced to the appropriate storage area at time of survey. 3. Each charge nurse will receive an in-service on the importance of storing oxygen and oxygen cylinders in appropriate storage areas at their next scheduled nurses meeting on 11/16/2016.	6-15-16 11-16-16

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A034	Continued From page 20 D. On 06/15/16 at 3:02 pm, during interview with Nurse (N) #13, she confirmed that the small oxygen cylinder tank was unsecured in the Unit-B medication room.	A034		
A036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the "2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value	A036		

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A036	Continued From page 21 and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. 8. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and	A036		

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A 036	Continued From page 22 (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection.	A 036		

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A036	Continued From page 23 (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days.	A036	7.6.2.36 D(2)(3) At time of inspection the Director of Dietary and Food Service began an audit and relabeling of all opened food items in the Facility refrigerators/freezers. All items on 6/14/16 that were identified as not properly labeled or stored were discarded from the kitchen. All other food items were audited and all opened food items were properly labeled and dated by 1700hr on that date. 1. The Food Service Director or designee will audit the refrigerators/freezers weekly at time of normal inventory for appropriate containers, labeling and dating. 2. An inservice of all dietary personnel was conducted 6/14/16 on the importance and steps of labeling and dating opened food items. 3. On 6/14/16 the maintenance director provided a thermometer in the kitchenette refrigerators that contain resident food items and the Director of Food Service began a daily temperature log on those kitchenette refrigerators.	6-14-16

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A036	A036 Continued From page 24 (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit, (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be	A 036	4. An in-service of all dietary personnel was conducted on 6/14/16 on the maintaining of a temperature log on the kitchenette refrigerators. The Food Service Director will check these logs weekly.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 036	Continued From page 27 when opened. C. On 06/14/16 at 3:00 pm, during interview with The Dietary/Housekeeping Manager, she confirmed the above findings *for* the food items in refrigerator #1 and the kitchen freezer. Findings related to temperature logs and thermometers: D. On 06/14/16 at 3:10 pm, during observation, there was no daily temperature log observed to be available for review *for* the refrigerator/freezer used to store resident food in the Unit-A kitchenette. E. On 06/14/16 at 3:10 pm, during interview with Staff (S) #1 and the Dietary/Housekeeping Director, they confirmed that there was no temperature log available *for* review for the refrigerator/freezer in the Unit A kitchenette. F. On 06/14/16 at 3:40 pm, during observation, there was no daily temperature log observed to be available for review *for* the refrigerator/freezer used to store resident food in the Unit-B kitchenette and there was no thermometer in either the refrigerator or freezer. G. On 06/14/16 at 3:40 pm, during interview with S #2, he confirmed there were no temperature logs available for review and that there was no thermometers in either the refrigerator or freezer.	A 036		
A 036	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The	A 038		

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A038	Continued From page 28 facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.38 A, B Based on observation and interview the facility failed to ensure: 1. That the electrical room next to Unit A was clean, free of safety hazards, has a straight access from entrance to panel, and working clearances of 36" in front of the panels and 30" to the sides were maintained at all electrical panels. 2. That combustible and flammable items were stored in approved closed metal cabinets in well ventilated areas. This deficient practice has the potential for all 54	A038	7NAMC 8.2.38 The electrical room has been cleared of all safety hazards and obstructions to electrical panel. 1. On 6/16/16 during the time of survey the maintenance crew removed all combustible and flammable items to be placed in the pre-designated area for such items. On 6/30/16 the shelving in the electrical room was removed to minimize any potential of storing items not appropriate for the room. With the removal of the shelves the clearances were easily met and there is no longer any obstruction to the pathway or in front of the electrical panel. 2. An additional storage facility off-site was procured to alleviate the storage concerns at the Facility. This was established 6/30/16. 3. The Maintenance Director will be checking the storage and electrical room on a monthly environmental safety walk.	6.16.16

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A038	Continued From page 29 (R #s 1-54) residents listed on the resident census, provided by the Administrator on 06/14/16 to be at risk of illness, injury, and/or death: 1. If a fire or other emergency requiring immediate access to the electrical panel and the direct path and working area are not maintained. 2. If in case of fire combustible and flammable items allowed vapors to spread throughout the building and has the possibility of igniting, creating a major fire. The findings are: A. On 06/16/16 at 8:34 am, during observation of the electrical closet next to Unit-A, the room was observed to be used for storage (sign on door states not a storage room). There was no direct route to the electrical panels or working clearances. Access to the panel was blocked with a large floor polisher, large plastic container used for documents to be shredded, and other items blocking the route from the door to the electrical boxes. The shelves and floor contained combustible and flammable items. The Maintenance Director (MD) confirmed the observation and stated that the Fire Dept said it was ok to use the room for storage if a warning sign was on the door. B. On 06/16/16 at 9:40 am, during observation the following combustible and flammable items were observed to be stored in the electrical closet next to Unit-A: 1. 1-462 gram can of paint remover epoxy (combustible) 2. 1-19oz can of carpet spot remover (flammable) 3. 1-20oz can of spray texture (flammable) 4. 1-32oz can of wood finish (combustible) 5. 1-13.5oz can of spray adhesive (extremely flammable)	A038		

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A 038	Continued From page 30 6. 1 evap-foam-no rinse (combustible-heat) 7. 2-25oz can of wall texture (flammable-combustible) 8. 1-3.75 gallon of paint thinner (Combustible-flammable) 9. 1-16oz aerosol can of bug spray 10. 5-32oz plastic bottles of liquid gun-go 11. 1 aerosol can of electrical grout 2-26 (flammable-combustible) C. On 06/16/16 at 9:56 am, during interview with the MD he confirmed that the above listed combustible and flammable items were stored in the electrical closet.	A 038	The Facility is committed to maintaining a facility in good repair at all times. On 6/16/16 while the survey was continuing the following repairs were made: 1. The shower staff lights were replaced and fixed to proper working order. There were no dry wall openings after repair. All light fixtures are checked for proper working order during the monthly environmental safety walk conducted monthly by the Director of Maintenance.	6-16-16
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.42	A042		

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A042	Continued From page 31 Based on observation and interview the facility failed to ensure that 1 of 4 light fixtures located above the shower stalls in the facility bathing rooms was securely placed in its socket in the ceiling, not hanging down by the wires, and allowing for penetration of the dry wall. If the light fixture is not secure, then the 27 residents on Unit A as listed on the resident census, provided by the Administrator on 06/14/16, are at risk of being injured if the light fixture should fall on them while being showered, come in contact with the water causing electrocution, and allowing smoke to penetrate the drywall if a fire were to occur. The findings are: A. On 06/16/16 at 6:53 am, during observation, the light fixture above the shower stall in Unit A (bathroom A) was observed hanging down from the socket by the wires and an open hole was observed in the ceiling drywall. B. On 06/16/16 at 8:30 am, during interview with the Maintenance Director, he confirmed that he was aware that the light fixture in the shower stall was hanging down from the socket by the wires and allowing for drywall penetration.	A042	7 NMAC 8.2.47 (B) (E) The Facility is committed to maintaining a facility with appropriately working lights and light fixtures. 1. On 6/15/16 while the survey was still in progress the maintenance crew replaced the emergency light in Unit A with a new fixture. It was in working by 1700hr. 2. The emergency light that had a dim indicator light was in need of new batteries. The batteries were replaced on 6/15/16 by the maintenance crew 3. The Maintenance Director will audit the indicator lights and all emergency lighting on the monthly environmental safety walk.	6-15-16
A047	7 NMAC 8.2.47 Lighting and Lighting Fixtures LIGHTING AND LIGHTING FIXTURES: A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area clearly visible. B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting. C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the	A047		

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A047	Continued From page 32 residents, with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff. and protected from accidental breakage or shattering. E. Facilities with four (4) or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service. F. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7.8.2.47 NMAC - Rp, 7.8.2.48 NMAC, 01/15/2010) This REQUIREMENT is not met as evidenced by: 7.8.2.47 B, E, Based on observation and interview the facility failed to ensure that the emergency lighting units and illuminated exit signs were in working condition. This deficient practice has the potential for the 27 (R #s 1-27) residents in Unit A as listed on the resident census, provided by the Administrator on 06/14/16, to be harmed if there were a fire or other emergency that required evacuation and the power was out. The findings are: A. On 06114116 at 3:30 pm, during observation the emergency lighting unit outside room #5 in Unit-A, was unable to be tested. The Maintenance Assistant confirmed that the unit was not working properly and needed to be replaced.	A 047		

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A 047	Continued From page 33 B. On 06/14/16 at 3:35 pm, during observation the emergency lights on the exit sign over the door near room #16 in Unit-A. were observed to be very dim. The Maintenance Assistant confirmed that the lights were dim and that the batteries needed to be replaced.	A 047		
A 048	7 NMAC 8.2.48 Electrical System ELECTRICAL SYSTEM: A. All fuse and breaker boxes shall be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility shall know the location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances shall be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear. (2) Extension cords shall not be used. The use of a multi-socket united laboratories approved (U/L APPROVED) surge protector with integrated circuit breaker no greater than six (6) feet in length is permitted for the intended purpose and not as an extension cord. [7.8.2.48 NMAC - Rp, 7.8.2.49 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.48 NFPA 70 (National Electric Code), 1999 Edition Article 410 410-56 (d) (e)	A 048		

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A048	Continued From page 34 (d) Faceplates. Metal faceplates shall be of ferrous metal not less than 0.030 in. (0.762 mm) in thickness or of nonferrous metal not less than 0.040 in. (1.016 mm) in thickness. Metal faceplates shall be grounded. Faceplates of insulating material shall be noncombustible and not less than 0.10 in. (2.54 mm) in thickness but shall be permitted to be less than 0.10 in. (2.54 mm) in thickness if formed or reinforced to provide adequate mechanical strength. (e) Position of Receptacle Faces. After installation, receptacle faces shall be flush with or project from faceplates of insulating material and shall project a minimum of 0.015 in. (0.381 mm) from metal faceplates. Faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Based on observation and interview, the facility failed to ensure that all outside electrical outlets had protective covers. This deficient practice has the potential for the 54 (R #s 1-54) residents listed on the resident census, provided by the Administrator on 06/14/16, to be at risk of harm if water or moisture should enter the outlet and cause a fire to occur. The findings are: A. On 06/14/16 at 3:05 pm, during observation, the outside electrical outlet on the (Unit-A) patio next to the coke machine did not have a protective cover B. On 06/14/16 at 3:19 pm, during observation, the outside electrical outlet next to the Unit A kitchenette did not have a protective cover. C. On 06/14/16 at 3:19 pm, during interview with the Dietary/Housekeeping Director, she	A048	7 NMAC 8.2.48 There were two electrical outlets that were identified by the surveyor that neglected to have protective covers. On the following day, 6/15/16, the Maintenance Director installed new protective covers to all outlets and did a facility wide walk-through to assure the Facility that all electrical requirements were met. 1. The Maintenance Director will inspect the electrical outlets on the monthly environmental safety audit for any broken or missing electrical covers.	6-15-16

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A048	Continued From page 35 confirmed that the 2 outside electrical outlets did not have protective covers. D. On 06/16/16 at 7:55 am, during observation, an outside electrical outlet (2nd socket to the left of the front door) was observed to not have a protective cover. E. On 06/16/16 at 8:30 am, during interview with the Maintenance Director, he confirmed the the outside electrical outlet (2nd to the left of the front door) did not have a protective cover.	A048	7 NMAC 8.2.61 1.Once the surveyor provided clarification on the requirements for sensitivity tests for smoke detectors, the contracted fire alarm and system contractor (Western States) was contacted to research the findings of the sensitivity test that was done on the last inspection of the fire system and the smoke detectors. Although the fire system and smoke detectors had been fully serviced in December, 2015 no documentation by the contractor on the sensitivity test could be obtained. Therefore, a. The Facility contracted with the contractor to provide a sensitivity test as described in the regulation for November 3, 2016 and then every two years thereafter in the month of November. b. The Maintenance Director has added the sensitivity test to the regular fire system and smoke detector service agreements and will be repeated November, 2018.	11-3-16
A061	7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: A. Fire alarm system. Facilities with four (4) or more residents shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction. B. Smoke and heat detection. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining and living room(s) must also be provided with smoke detectors. (1) Detectors shall be powered by the house electrical service and have battery back up. (2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room. (3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service.	A061		

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A061	Continued From page 39 causing the fire alarm system to not operate properly.	A061	7 NMAC 8.2.63	
A063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A IOBC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 B Based on observation and interview, the facility failed to ensure that 1 of 5 fire extinguishers in Unit B had been inspected annually and monthly to ensure proper working order in case of fire. If the fire extinguishers are not inspected as required, then all 27 (R #1-27) residents of Unit-B are at risk of harm if there is a fire and the fire	A063	The Facility maintains a contract with Western States for the annual servicing of the fire extinguishers. The last contractor visit was on December, 2016 where an inspection of the fire extinguishers was completed. On 6/16/16 the contractor was called and arrived at the facility to inspect the 1out of 5 extinguishers with a non-inspection tag. The fire extinguisher was inspected and serviced and provided a tag of current inspection. 1. The Facility will maintain the current yearly inspection and has scheduled this for every December. All fire extinguishers are current and will be re-inspected in December, 2016. 2. The Maintenance Director will check each fire extinguisher tag monthly on the monthly environmental safety walk through.	6-16-16

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A063	Continued From page 40 extinguisher does not work properly. The findings are: A. On 06/14/16 at 11:15 am, during observation, the fire extinguisher across from room #9 in Unit-8 revealed that it had not been inspected since December 2014. B. On 06/14/16 at 12:17 pm, during interview with the Maintenance Director, he confirmed that the fire extinguisher in Unit-8 across from room #9 had not been inspected since December 2014.	A063		
A068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A Definitions: inaddition to the requirements for all assisted living facilities pursuant to " DEFINITIONS," 7.8.2.7 NMAC, the following definitions shall also apply. (1) "Hospice agency" means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) "Hospice care" means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable	A068		

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A068	Continued From page 41	A 068		

symptoms.
(3) "Licensed assisted living provider" means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health.
(4) "Hospice services" means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members.
(5) "Care coordination requirements" means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services.
(6) "Palliative care" means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure.
(7) "Terminally ill" means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live.
(8) "Visit notes" means the documentation of the services provided for hospice residents and includes ongoing care coordination.
B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services:
(1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident's ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and
(2) offer an ongoing employee psychological support program for end of life care issues.
C. Individual service plan (ISP) requirements.
(1) Each resident who receives hospice services

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A068	Continued From page 42 shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination.	A068	7 NMAC 8.2.68 The Facility is committed to providing quality end-of-life care for residents in collaboration with hospice services. The education program for staff is accomplished through the use of on-line web based tutorials, a video library available to staff on specific topics, and group classes facilitated by skilled educators. The Facility made the following changes to increase staff education in hospice services: 1. The education library of video training in hospice was increased by adding 2 new videos for staff access. 2. The education nurse increased her small group classes by 4 a month to increase availability to education by staff. 3. A staff position (scheduling and education coordinator) was created to audit staff education every 6, 10 and 12 months to provide coaching and information to employees on their education hours and status	7-5-16 7-1-16 10-1-16

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A066	Continued From page 43 (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with "Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident's record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident's record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident's condition and care needs. (b) The assisted living facility shall receive	A066	4. The Facility coordinated with a hospice to provide 4 in-services a year on hospice services to increase large group sessions available to staff members. 5. The Facility facilitated a Hospice Education month in July, 2016 which facilitated employee involvement with hospice education. From July 5-July 20th employee supervisors coordinated all employees to receive additional training in hospice care to ensure that the employee group was supported in hospice education. a. As each employee's education year is determined by their hire date, an audit of all employee education hours which included hospice hours was completed on 10/28/16.	10-1-16 10-28-16

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A068	Continued From page 44 information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified. E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident	A068	b. The new position of education and scheduling coordinator has prioritized employees in their 10-12month of their calendar year to coach them through completion of all required education hours by their anniversary date. This new process of tracking and coaching employees will result in full compliance of employees receiving their yearly education in hospice and other required topics. The Director of Operations is responsible for assuring that the staff audits and coaching continue as a regular part of daily operations. c. November 15-18 2016 are dedicated all staff meetings on hospice care in the facility. The specific topic annually in November is "Dementia & Hospice" which will be presented and continues to provide opportunities for the staff to complete their 6 required hours of hospice education.	10-1-16 11-16-16

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A068	Continued From page 45 Considered "hospice general inpatient" which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. (7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT Is not met as evidenced by: 7.8.2.68 B (1), D (2) Based on record review and interview the facility failed to ensure that: 1. Resident Care Staff (RCS) received annually, an additional 6 hours of hospice specific training. 2. The facility convened a team meeting prior to accepting or retaining residents on hospice or who may require a higher level of care than the facility would normally provide, to review and agree that the facility can meet the needs of the resident, while still ensuring the safety and welfare of the other residents and staff. This deficient practice has the potential for the 54 (R #s 1-54) residents listed on the resident census provided by the Administrator on 08/14/16 to be at risk of: 1. Not receiving the individual end of life care and services needed if they elect to receive hospice benefits from an outside provider, if the RCS have not received/completed the additional 6-hours of annual hospice specific training. 2. Harm or injury if residents who require a higher level of care than the facility and staff can provide are admitted or retained placing other residents and staff at risk. The findings are: Findings related to staff training:	A068	6. It is the practice of the facility to provide care coordination between hospice staff and the Facility prior to admission to hospice despite lack of documentation. Effective 7/1/16 the facility began using a form: "Care Coordination and Care Planning" which documents the interaction and participants of the care coordination meetings between outside services (hospice) and the facility. The form also provides for the assertion that the resident can receive appropriate services in the facility based on the new status of hospice. A physician's signature is also present as a member of the Team. This care coordination meeting takes place prior to the admission of the resident to Hospice. The Director of Nursing will ensure on-going compliance for the new form and process.	

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A068	Continued From page 46 A. Record review of RCS #1's Annual Training/Education Record revealed, that she only completed 1-hour of the required 6-hours of hospice specific training between her hire date of 01/31/15 and 01/30/16. B. On 06/16/16 at 11:10 am, during interview with the Director of Operations (000), he confirmed that RCS #1 only completed 1-hour of the required 6-hours of annual hospice specific training. C. Record review of RCS #2's Annual Training/Education Record revealed, that she only completed 1-hour of the required 6-hours of hospice specific training between her anniversary date of 04/12/15 and 04/11/16. D. On 06/16/16 at 11:11 am, during interview with the 000, he confirmed that RCS #2 only completed 1-hour of the required 6-hours of annual hospice specific training. E. Record review of RCS #3's Annual Training/Education Record revealed, she only completed 2-hours of the required 6-hours of annual hospice specific training between her anniversary date of 06/01/15 and 05/31116. F. On 06/16/16 at 12:43 pm, during interview with the 000, he confirmed that RCS #3 only completed 2-hours of the required 6-hours of annual hospice specific training. G. Record review of RCS #4's Annual Training/Education Record revealed that he only completed 1-hour of the required 6-hours of hospice specific training between his anniversary date of 01/16/15 and 01/15/16.	A068		

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A068	Continued From page 47 H. On 06/16/16 at 12:44 am, during interview with the DOO, he confirmed that RCS #4 only completed 1-hour of the required 6-hours of annual hospice specific training. Findings related to team meetings: I. Record Review of R #5's resident chart revealed no documentation that an admission/retention team meeting was convened prior to her admission to hospice on 10/12/15. J. Record Review of R #'s resident chart revealed no documentation that an admission/retention team meeting was convened prior to her admission to the facility with hospice services on 06/14/16. K. Record Review of R #S's resident chart revealed no documentation that an admission/retention team meeting was convened prior to his admission to hospice on 05/15/15. L. Record Review of R #9's resident chart revealed no documentation that an admission/retention team meeting was convened prior to his admission to hospice on 10/12/15. M. On 06/17116 at 11:06 am, during interview with the DOO, Director of Nursing (DON) and Nurse Supervisor (NS #1), they confirmed that facility did not conduct admission/remission team meetings prior to admitting/retaining R #s 6-9 who are receiving hospice services.	A068		
A069	7 NMAC 6.2.69 Memory Care Units MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve	A069		

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A 069	Continued From page 48 residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions: The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply. (1) "Alzheimer's" means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer's gets progressively worse and is fatal. (2) "Care coordination agreement requirement" means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services. (3) "Dementia" means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain. (4) "Memory care unit" means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer's disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program. (5) "Secured environment" means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit. B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process. (1) The medical diagnosis and ISP shall be	A 069		

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A 069	Continued From page 49 utilized in the determination of the need for additional services. (2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided inthe facility by an outside health care provider. C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information. D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria: (1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs; (2) medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it;	A 069		

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A069	Continued From page 60 (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. E. Assessments and reevaluations. (1) An assessment shall be completed by a registered nurse or a physician extender within fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5) days after admission. (a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission. (b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit. (c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted. (2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident's stay in the assisted living facility memory care unit is still appropriate. F. Documentation in the resident's record. In addition to the required documentation pursuant	A069		

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A069	Continued From page 51 to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record: (1) the physician ' s diagnosis for admission to a secure environment or a memory care unit; (2) the pre-admission assessment; and (3) there-evaluation(s). G. Secured environment. (1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to: (a) double alarm systems; (b) gates connected to the fire alarm; and (c) tab alarms for residents at risk for elopement (2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents. (a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate	A069	7 NMAC 8.2.69 C, E (I)(b) The Facility is committed to providing 12 hours of training per year related to dementia to each employee. A diverse education program has been created which includes the use of a web based interactive training module system provided by the National Institutes of Health for dementia caregivers, small group workshops taught by skilled educators, a library of specialized videos on dementia care, and a self-directed library of written dementia information. To ensure that each employee participates in the education program that is available to them the following changes have been made to daily operations: 1. At the time of survey the Director of Operations was in the midst of seven small group mandatory employee meetings (June 7, 14, 16, 21, 23, 28, 30) which had been established by the Facility to instruct all employees on the education policy and on their responsibilities in obtaining their required education.	

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	2171	A. BUILDING: _____ B. WING: _____	C 06/17/2016

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RETREAT (THE)	4075 JACKIE RDSE RIO RANCHO, NM 87124

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A 069	Continued From page 52 such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident ' s legal representative, if applicable and prior to the resident's admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for. (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010) This REQUIREMENT is not met as evidenced by: 7.8.2 69 C, E (1) (b) Based on record review and interview, the facility failed to ensure that: 1. Resident Care Staff (RCS) completed an additional 12 hours of dementia specific training. 2. Physician's order's that included a diagnosis of Alzheimer's or other dementia and the resident's need for a secured unit were obtained prior to admission. This deficient practice has the potential for all 54	A069	2. These meetings provided a basis for the Facility to improve overall compliance with the established education program. 3. The Director of Operations was provided a new position of Scheduling and Education Coordinator whose role is to provide regular audits for each employee at their sixth, tenth and 12th month of employment. This new role will assure the Director that all employees are provided information and coaching in meeting their education requirements. This position started 10/1/16. 4. The employee education Computer areas were expanded on 7/1/16 to double the capacity for on-computer users. This allowed for more employees to utilize the web based online training at the same time. 5. The on-site video library was expanded with 3 additional, relevant videos on dementia care giving to provide expanded choice and access to employees in obtaining their dementia education.	10-1-16 7-1-16 7-5-16

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A069	Continued From page 53 (R #1-54) residents (with dementia) listed on the resident census, provided by the Administrator on 06/14/16 to be at risk of: 1. Not receiving the individual (physical, mental, social) care and services residents with dementia require because the RCS have not completed the required annual specialized dementia training. 2. Being inappropriately placed in a secured/memory care unit if there is no physician's order including the diagnosis and reason for the need for a secured unit. The findings are: Findings related to dementia specific training: A. Record review of RCS #1's training records revealed that she only completed 11.5 hours of the required additional 12-hours of dementia specific annual training between her hire date of 01/31/15 and 01/30/16. B. On 06/16/16 at 11:10 am, during interview with the Director of Operations (DOO), he confirmed that RCS #1 only completed 11.5 hours of the required 12-hours of the dementia specific training. C. Record review of RCS #2's training records revealed that she only completed 3.25 hours of the required additional 12-hours of dementia specific annual training between her anniversary date of 04/12/15 and 04/11/16. D. On 06/16/16 at 11:11 am, during interview with the DOO, he confirmed that RCS #2 only completed 3.25-hours of the required 12-hours of the dementia specific training. E. Record review of RCS #3's training records	A069	6. The administrative team of directors for all departments received an inservice on 9/13/16 on the importance of employee coaching and on the new position of scheduling and education coordinator's role and function which began 10/1/16. 7. The nurse educator's role was expanded by an additional 8 hours a week to include more 1:1staff training to new employees and to employees whose 10th month audit deemed them nearing a deficiency status. The nurse educator will work collaboratively with the new position of Scheduling and Education Coordinator to provide additional educational opportunities so that all employees reach full compliance in their education hours by their annual anniversary date.	9-13-16 10-1-16

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A069	Continued From page 54 revealed that she only completed 8-hours of the required 12-hours of dementia specific training between her anniversary date of 06/01/15 and 05/31/16. F. On 06/16/16 at 12:43 pm, during interview with the DOO, he confirmed that RCS #3 only completed 8-hours of the required 12-hours of the dementia specific training. Findings related to physician orders for placement in a secured unit: G. Record review of R #1's resident file revealed no physician's order for placement in a secured unit. H. Record review of R #2's resident file revealed no physician's order for placement in a secured unit. I. Record review of R #6's resident file revealed no physician's order for placement in a secured unit. J. Record review of R #I's resident file revealed no physician's order for placement in a secured unit. K. Record review of R #B's resident file revealed no physician's order for placement in a secured unit. L. Record review of R #9's resident file revealed no physician's order for placement in a secured unit. M. On 06/17/16 at 11:06 am, during interview with the DOO, DON, and NS #1, they confirmed that there were no physician orders for placement	A069		

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A069	Continued From page 55 In a secured unit for R #'s 1, 2 and 6-9.	A069		
A070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.70 F 7.8.2 A, B 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 8. (2)	A070		

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A070	Continued From page 56 W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor ' s order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division ' s incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau ' s incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure that all incidents of suspected or known resident abuse, neglect, or unusual occurrence which has or could threaten the health, safety, or welfare of the residents were reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. That an internal investigation was conducted within 5 business days and submitted to the Licensing Authority for 5 of 5 (R #s 1, 3, 4,	A070	7 NMAC 8.2.69 E (1)(b) The Facility's practice had been to provide an assessment prior to admission by the Administrator. The assessment was not formally recorded in the resident record so the following changes to procedures and documentation were made effective 7/1/16 after clarification of the regulation with the surveyor: 1. A specific assessment form was created that included all required aspects of assessment listed in the regulation and also included an assessment of neuropsychiatric features relevant to dementia. This new more formal assessment also includes the assessment conclusions on less restrictive environments. Additionally, a physician's order for placement consistent with the assessment has been added to the formal assessment to meet the requirement of a physician's Order.	7-1-16

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A070	Continued From page 57 10 and 11) resident records reviewed for for incident reporting compliance. This deficient practice has the potential for residents to be at risk of being abused, neglected, and/or not receiving needed medical care and services if incidents are not being reported as required. If the facility is not conducting internal investigations and submitting their findings to the Licensing Authority, then residents are at risk of continued suffering and further injury if there is no oversite of the care and services the facility is providing. The findings are: A. Record review of a facility incident report and incident report communication to the physician dated 01/09/16 revealed that a 2:30 am, R #10 was found on the floor with her head against her roommates night stand. R #10 stated she was pushed to the floor by her roommate. R #10 suffered a broken hip. There was no documentation available to indicate that the facility reported the incident to the Licensing Authority or submitted a 5-day follow-up investigation report. B. Record review of a facility incident/accident report dated 03/24/16 revealed that at 6:20 pm, a male resident was found naked in R #3's bed. R #3 was found to have a skin tear on her right (R) anterior (front) forearm. The incident was unwitnessed. There was no documentation available to indicate that the facility reported the incident to the Licensing Authority or submitted a 5-day follow-up in investigation report C. Record review of a facility incident/accident report dated 04/13/16 and daily progress notes revealed that at 1:30 pm, R #11 was found to have 2 nail marks on her left (L) forearm, that looked to be several days old, scabbed-over and	A070	2. All current residents residing at the facility were reviewed by the medical director for a current order to continue residing in a secured unit and that no other less restrictive environment was appropriate. These orders are now established on the resident's admitting medication and treatment record.	11-1-16

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A070	Continued From page 57 10 and 11) resident records reviewed for for incident reporting compliance. This deficient practice has the potential for residents to be at risk of being abused, neglected, and/or not receiving needed medical care and services if incidents are not being reported as required. If the facility is not conducting internal investigations and submitting their findings to the Licensing Authority, then residents are at risk of continued suffering and further injury if there is no oversite of the care and services the facility is providing. The findings are: A. Record review of a facility incident report and incident report communication to the physician dated 01/09/16 revealed that a 2:30 am, R #10 was found on the floor with her head against her roommates night stand. R #10 stated she was pushed to the floor by her roommate. R #10 suffered a broken hip. There was no documentation available to indicate that the facility reported the incident to the Licensing Authority or submitted a 5-day follow-up investigation report. B. Record review of a facility incident/accident report dated 03/24/16 revealed that at 6:20 pm, a male resident was found naked in R #3's bed. R #3 was found to have a skin tear on her right (R) anterior (front) forearm. The incident was unwitnessed. There was no documentation available to indicate that the facility reported the incident to the Licensing Authority or submitted a 5-day follow-up in investigation report. C. Record review of a facility incident/accident report dated 04/13/16 and daily progress notes revealed that at 1:30 pm, R #11was found to have 2 nail marks on her left (L) forearm, that looked to be several days old, scabbed-over and	A070	7 NMAC 8.2.70 F Upon clarification of the regulation at time of survey the Facility made the following changes to their reporting of incidents: 5. A policy was drafted that outlined the full regulation and the appropriate steps for staff to follow in identifying, reporting and investigating incidents. Although the facility had maintained a practice of incident reports, notification to physician and responsible parties, and providing investigation and follow-up to all incidents, the new policy clarifies the steps for nursing and administrative personnel in when to report any suspected cases or known incidents of resident abuse, neglect or exploitation, injuries of unknown origin and other events. The updated policy provides clear steps in utilizing the state's incident management system.	

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A070	Continued From page 58 bruised. Cause of the injury was unknown. There was no documentation available to indicate that the facility reported the incident to the Licensing Authority or submitted a 5-day follow-up in investigation report D. Record review of a facility Incident/accident report dated 05/07/16 revealed that at 1:45 pm, an unwitnessed resident to resident verbal and physical altercation occurred between R #1 and R #10. When staff arrived after hearing R #1 yell "Help Me", R #10 was observed holding and pushing R #1 to the ground by holding her arms very tightly. R #1 was found to have mild bruising and a small skin tear to her R-front forearm. There was no documentation available to indicate that the facility reported the incident to the Licensing Authority or submitted a 5-day follow-up investigation report. E. Record review of the facility incident/accident report and daily progress note dated 05/24116 revealed that at 7:15 am, R #4 was found to have an injury (laceration) of unknown origin on the L-side of her head, bruising was occurring, dried blood was observed and appeared to have been cleaned. Resident was not able to say how the injury occurred. There was no documentation available to indicate that the facility reported the incident to the Licensing Authority or submitted a 5-day follow-up in investigation report. F. On 06121/16 at 12:35 pm, during interview with the Director of Nursing (DON) she confirmed that the facility did not report the incidents for R #s 1, 3, 4, 10, and 11 to the Licensing Authority and that the facility is not documenting any internal follow-up investigations or submitting them to the Licensing Authority within 5 days.	A070	6. As of 6/21/16 all incidents that met the stated guidelines were reported within 24 hours and a follow up report was provided to the state within 5 days. There have been 5 incidents reported between 6/2016 and 10/2016. None of the reported incidents were identified as abuse. 7. All directors of the facility were updated to the new policy during the time survey was taking place. Administrative nurses were provided additional in-services on the updated policy on 8/4/2016. 8. An additional policy was developed for the specific incident of "Resident to Resident" incident. It mirrors the overall policy of reporting incidents identified in #1,but enhances steps for nursing to take in the evaluation process of identifying precursors and non-pharmacological steps to Consider when investigating a resident to resident incident. All nurses will have completed their In-service on this additional nursing policy by 11/15/16	