Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
SECOND SET	5280	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DEL VALLE I SHELTER CARE	2111 RAVEN LANE SW ALBUQUERQUE, NM 87105

(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
A20	7 NMAC 8.2.20 Admissions/ Discharge Agreement 7.8.2.20 ADMISSION/DISCHARGE AGREEMENT: The facility must establish an admission agreement for each resident. A. The admission agreement must include the following information: (1) The parties to the agreement. (2) The scope of services to be provided. (3) The cost of services and method of payment. (4) The circumstances under which the Agreement may be terminated. (a) Termination of admission agreements shall be upon at least fifteen (15) days written notice, to the resident and his or her agent or guardian, where applicable, unless the resident requests termination. (b) The facilities bed hold policy. (c) An admission/discharge agreement may provide for termination by the facility when the resident's health has improved sufficiently the resident no longer needs the services provided by the facility. (d) Termination of an admission agreement by the facility is permitted in emergency situations for the following reasons: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; the safety or health of individuals in the facility is endangered; the resident has failed to pay for a stay at the facility, as defined in the admission agreement; the facility ceases to operate or is no longer able to provide services to the resident; and due to sanctions or remedies imposed by the Department. B. A new or amended admission agreement must be executed whenever services, costs or	A20	ES scanned 01-08-09 RECEIVED JAN 08 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION SECOND SET	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5280	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DEL VALLE I SHELTER CARE	2111 RAVEN LANE SW ALBUQUERQUE, NM 87105

(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
A20	Continued From page 1 other material terms are changed. [7-11-86, 1-11-90, 4-7-97; 7.8.2.20 NMAC - Rn, 7 NMAC 8.2.20, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.20(A)(2) - Admission Agreement Based on record review and interview, the facility failed to provide an admission agreement that gave accurate information regarding the scope of services provided to 4 of 4 sampled residents. The findings are: A. On 9/25/08 at 1:30 PM during record review, it was noted that the admission agreement contains information that is not accurate for Resident #1, #2, #3, and #4. The "Program Narrative for Assisted Living Homes" given to and signed by residents as part of their admission agreement states that, "our on-site caregivers are medication aid certified, first aid and CPR certified". B. On 9/25/08 at 1:30 PM during interview with the Administrator, she stated that it is being worked on.	A20	① All staff / caregivers are CPR certified. All staff are certified to Assist residents with Self Administration of their medications; Staff are certified through either Program Narrative will be updated. (A) Assisting with Self Administration and First Aid though the Assisted Living Services Org. or (B) Assisted with Medications the Right way through the New Mexico Health Care Assoc. ② All employee will be required to complete a State DOH approved Assisting with Self Administration / medication course and a CPR course. Facility will correct/update Program	
A32	7 NMAC 8.2.32 Handling of Emergencies 7.8.2.32 HANDLING OF EMERGENCIES: A. Each resident or resident representative shall designate upon admission, a physician to be called in case of medical necessity. Each resident or representative may also designate a concerned person to be called in case of an emergency. The facility shall establish a policy to secure medical assistance if the resident's own physician is not available. In the event of an illness or an injury to the resident, an appropriately licensed health professional must	A32		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
SECOND SET	5280	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DEL VALLE I SHELTER CARE	2111 RAVEN LANE SW ALBUQUERQUE, NM 87105

(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
A32	Continued From page 2 be notified by the facility. B. The facility must have available, a first aid kit containing gauze, tape, adhesive, antiseptic, and bandages for emergencies. The first aid kit must be kept in a designated, easily accessible place within the facility. C. An easily accessible and functional telephone for summoning help in case of an emergency must be available in each facility. A pay telephone will not fulfill this requirement. D. A list of emergency numbers, including, but not limited to, Fire Department, Police Department, Ambulance Services, Poison Control, Licensing and Certification, Adult Protective Services, and Ombudsman must be posted near each public telephone in the facility. [7-1-64, 9-15-70, 5-26-72, 7-19-75, 9-24-76, 7-11-86, 1-1-90, 4-7-97; 8.2.32 NMAC - Rn, 7 NMAC 8.2.32, 8-31-00] This REQUIREMENT is not met as evidenced by: Refers to NMAC 7.8.2.32 (D) - List of Emergency Phone Numbers Based on observation and interview, the facility failed to ensure that all required emergency phone numbers were listed on the emergency contact list. The findings are: A. On 9/25/08 at 12:30 PM during a tour of the facility, it was observed that there was not an easily accessible public phone located in the resident area of the facility. Surveyor asked Staff #2 where the resident phone was located and she went to get the phone in a part of the facility where residents are not allowed to enter. B. On 9/25/08 at 12:30 PM during a tour of the facility, it was noted that all required emergency phone numbers were not posted on a list and	A32 3.2.D)	Narrative to delete verbage "Medication Aid Certified". (3) Mang will upon ~~not~~ hire and required re-certification require that all staff complete an approved CPR course and an approved course in Assisting Residents with Self Administration of Medications. (4) 10/~~0~~/08. (1) A public phone was installed in Resident's Living area and ~~the~~ Listed emergency phone Numbers posted near phone. (2) Phone installed and made accessable to all Residents at any time of day. (3) Facility will maint. phone and emergy phone list. for Residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
SECOND SET	5280	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DEL VALLE I SHELTER CARE	2111 RAVEN LANE SW ALBUQUERQUE, NM 87105

(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
A32	Continued From page 3 available to residents. C. On 9/25/08 at 12:45 PM during an interview with the administrator, she showed surveyor a list of emergency phone contacts but also stated that residents were not allowed in that particular part of the facility. Administrator acknowledged that residents do not always have access to a public phone.	A32	(4) 10/3/08	
A36	7 NMAC 8.2.36 Medications 7.8.2.36 MEDICATIONS: Medications will be administered or staff assistance with medications provided and documented in accordance with state and federal laws. A. Licensed health care professionals are responsible for the administration of medications. B. Facility staff may assist a resident with medications if written consent by the resident is given to the director of the facility or their designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with medications. All staff assisting with medications shall have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications. C. No medications, including over the counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order by the physician and entry into the resident's record. D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and	A36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
SECOND SET	5280	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DEL VALLE I SHELTER CARE	2111 RAVEN LANE SW ALBUQUERQUE, NM 87105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A36	Continued From page 4	A36		

side-effects.

E. Medications prescribed for one resident shall not be used for another resident.

F. The facility shall have a Medication Administration Record (MAR) documenting medications administered to residents, including over-the-counter medications. This documentation shall include:

(1) Name of resident.
(2) Date started.
(3) Drug product name.
(4) Dosage and form.
(5) Strength of drug.
(6) Route of administration (e.g. "by mouth").
(7) How often medication is to be taken.
(8) Time taken and staff initials.
(9) Dates when the medication is discontinued or changed.
(10) The name and initials of all staff administering medications.

G. Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting.

H. PRN Medications: The use of PRN medications must be closely monitored and supervised by the facility and is based on one or more of the following conditions:

(1) The resident is capable of determining when the medication is needed.
(2) The resident's physician has provided detailed instructions to the pharmacy regarding the administering of the medication. The physicians instruction for a PRN medication shall include:
(a) Symptoms that might indicate the use of the medication.
(b) Exact dosage to be used.
(c) The exact amount of medication to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
SECOND SET	5280	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DEL VALLE I SHELTER CARE	2111 RAVEN LANE SW ALBUQUERQUE, NM 87105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A36	Continued From page 5 be used in a 24 hour period. (d) Directions as to what to do if the symptoms persist. (e) Possible interactions or side-effects that might occur. (f) Manufacturer's label information for directions if deemed adequate by the physician. I. The facility must report all medication errors to the physician. J. The facility shall develop and follow a written policy for unused, outdated, or recalled medications being kept in the facility. [7-1-64, 9-15-70, 7019074, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.36 NMAC - Rn, 7 NMAC 8.2.36, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.36(C) - Not following MD Orders Based on record review and interview, the facility failed to ensure that physician orders were followed for 3 of 4 sampled facility residents. This has the potential to negatively impact 100% of residents. The findings are: A. On 9/25/08 at 12:30 PM during resident record review, it was noted that Resident #1, #2, and #3 did not have any physician orders on file and they were all being assisted with medications on a daily basis by facility staff. B. On 9/25/08 at 1:30 PM during interview with Administrator, she acknowledged that the stated residents did not have any physician orders on file.	A36	(1) Facility will request and keep on file physician's orders for all ~~new~~ resident medications. Facility staff will follow physicians orders on all medication and ensure that MAR's correctly and accurately read physician's orders. (2) Mary will review all resident's medications and MARs to ensure that physicians orders are available and being followed correctly. (3) Mary will on a weekly basis and on a monthly printing of MARs review MARs to ensure accuracy to physicians orders. Mary will upon ~~and~~ admission	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
SECOND SET	5280	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DEL VALLE I SHELTER CARE	2111 RAVEN LANE SW ALBUQUERQUE, NM 87105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A36	Continued From page 6 Refer to 7.8.2.36(C) - Changing medication dosage without MD Orders Based on observation, record review and interview, the facility failed to ensure that medications were given as prescribed for 1 of 4 residents (Resident #2). This has the potential to negatively affect all Resident medication dosing. The findings are: A. On 9/25/08 at 1:00 PM during observation of the physical medication containers for Resident #2 the following was noted: -IBU 800 mg to be given 1 tab orally twice per day -Dilantin 100 mg to be given 3 caps orally at bedtime B. On 9/25/08 at 1:05 PM during review of the MAR (Medication Administration Record) it was noted that the following transcriptions were noted for Resident #2's medications: -Ibuprofen 800 mg to be given 1 tab every 8 hours - PRN (MAR shows medication is being given once a day, routinely) -Dilantin Kapseal 100 mg to be given 4 caps orally at night C. On 9/25/08 at 1:05 PM during review of residents file there were no physician orders available to clarify medication regimen ordered by physician. D. On 9/25/08 at 1:15 PM during interview with the Administrator, she stated that the resident did not have any physician orders on file and that she follows the regimen that is listed on the MAR. Surveyor asked who prints the MAR's and Administrator stated that her husband prints the	A36	and addition/change of and medication ensure that a Physicians Orders are avail and berry followed accurately. (F) 10/1/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
SECOND SET	5280	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DEL VALLE I SHELTER CARE	2111 RAVEN LANE SW ALBUQUERQUE, NM 87105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A36	Continued From page 7 MAR and gets the information for the MAR from the bottles of medication delivered by the pharmacy.	A36		
A63	7 NMAC 8.2.63 Staff & Residient Fire & SafetyTraining 7.8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff personnel of the facility must know the location of and be instructed in proper use of fire extinguishers and other procedures to be observed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff must be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways, and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident must upon being accepted into the facility be given an orientation tour of the facility to include, but not be limited to, the location of the exits, fire extinguishers, and telephones, and shall be instructed in action to be taken in case of fire or other emergency. D. Fire Drills: The facility must conduct at least one (1) fire drill each month: (1) Fire drills must be held at different times of the day. (2) The fire alarm system or detector system in the facility shall be used in the conduct of fire drills. (3) In the conduct of fire drills, emphasis must be placed upon orderly evacuation under proper discipline rather than upon speed.	A63		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
SECOND SET	5280	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DEL VALLE I SHELTER CARE	2111 RAVEN LANE SW ALBUQUERQUE, NM 87105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A63	Continued From page 8 (4) A record of fire drills held must be maintained on file in the facility. Such record must show date and time of the drill, number of personnel participating in the drill, any problem noted during the drill and the evacuation time in total minutes. (5) The local fire department should be requested to supervise and participate in fire drills. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.63 NMAC - Rn, 7 NMAC 8.2.63, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.63 - Staff Fire Safety Training Based on record review and interview, the facility failed to have required staff training for 3 of 5 sampled staff. The findings are: A. On 9/25/08 at 11:30 AM, record review revealed no documentation of fire safety training for Staff Members #1, #2, and #3. B. On 9/25/08 at 11:35 AM during an interview with the Administrator, she acknowledged that there was no documentation available showing the training had been completed.	A63	(1) All staff will complete a Fire Safety Training sessions as required. (2) Mang will review all employee file to ensure that a Fire Safety Course is completed immediately and upon required re certification. (3) Mang will upon hire and required re certification timelines ensure that all employees complete a Fire Safety course/training. (4) 10/1/08	
A66	7 NMAC 8.2.66 Related Regulations & Codes 7.8.2.66 RELATED REGULATIONS AND CODES: Adult residential care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows: A. Health Facility Licensure Fees and	A66		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
SECOND SET	5280	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DEL VALLE I SHELTER CARE	2111 RAVEN LANE SW ALBUQUERQUE, NM 87105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A66	Continued From page 9 Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96). B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96). C. Adjudicatory Hearings, New Mexico Department of Health, 7 NMAC 1.2 (2-1-96). [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.66 NMAC - Rn, 7 NMAC 8.2.66, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to NMAC 7.1.9.8 - Caregivers Criminal History Screening Requirements (Effective January 1, 2006) - All applicants to whom an offer of employment is made must consent to a nationwide and statewide screening. Based on record review and interview, the facility failed to have documentation that direct care staff had been cleared through the New Mexico Caregivers' Criminal History Screening Program (CCHSP) for 3 of 5 employee. The findings are: A. On 9/25/08 at 11:50 AM during review of employee records, it was noted that Staff #2, #4 and #5 did not have on file documentation of CCHSP statewide update screening addressed to the current facility of employment and conducted subsequent to hire within the required timeframe nor documentation of a full Caregivers Criminal History Screening (CCHSP) clearance addressed to the current facility of employment and conducted subsequent to hire within the required timeframe. B. On 9/25/08 at 12:15 PM during interview with the administrator, she acknowledged the problem	A66	(1) All employees will ensure that a CCHSP clearance and letter providing ~~proof~~ proof of screening is addressed/sent to facility. (2) Mang will review all employee file to ensure that a CCHSP screening is completed and sent/addressed to facility. (3) Mang will upon hire ensure that a CCHSP is completed and that facility receives and original copy of clearance letter and ~~proof~~ proof completion of screening that is addressed to facility. (4) 10/25/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
SECOND SET	5280	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DEL VALLE I SHELTER CARE	2111 RAVEN LANE SW ALBUQUERQUE, NM 87105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A66	Continued From page 10 and stated that she would request the documentation. Refer to NMAC 7.1.13.10(C)(1)(a-f) Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Incident Management System Training Curriculum Requirements on incident policies and procedures, timely reporting, unexpected deaths and other reportable incidents. Based on record review and interview, the facility failed to ensure training on Incident Management System with the required curriculum for 3 of 5 staff members. The findings are: A. On 9/25/08 at 11:40 AM during review of the employee files it was noted that the required training documentation for abuse, neglect and exploitation, and reporting requirements for NMAC 7.1.13 for the fiscal year 2009 was not among administrative paperwork for Staff #2, #4 and #5. B. On 9/25/08 at 11:40 AM during interview with the Administrator, she acknowledged that the stated staff members did not have the training and no documentation of the training was available.	A66	① All employees will complete required Incident Mang training. ② Mang will review all file to ensure that all employees and newly hired employees complete all required Incident Mang Training. ③ Mang will upon hire and required training periods ensure that all employees complete an Incident Mang Training program. ④ 10/1/08	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
SECOND SET	5280	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DEL VALLE I SHELTER CARE	2111 RAVEN LANE SW ALBUQUERQUE, NM 87105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A66	Continued From page 11 Refer to NMAC 7.1.13.10(F) - Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Posting of Incident Management Information Poster Based on observation and interview, the facility failed to ensure that the division Incident Management Information poster was posted as required. The findings are: A. On 9/25/08 at 11:10 AM and throughout the course of the survey, it was noted that the 2009 Incident Management Information Poster was not seen posted anywhere in the facility. B. On 9/25/08 at 12:00 PM during an interview with the Administrator, she acknowledged the matter and stated that she would address the issue.	A66	(1) Facility will post Incident Mang Information poster as required. (2) Mang will ensure that Incident Mang Information poster is posted and maintained in a visable location. (3) Mang/owner will inspect on a monthly basis to ensure that Incident Mang Information poster is posted as required. (4) 10/1/08	