PRINTED: 12/27/2006
FORM APPROVED

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5772	A. BUILDING _____ B. WING _____	12/27/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADOBE ASSISTED LIVING #1 (THE)	1111 E MOUNTAIN LAS CRUCES, NM 88001

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A17	7 NMAC 8.2.17 PERSONNEL 7.8.2.17 PERSONNEL: The adult residential care facility must have and implement written personnel policies. The personnel policies must address the following: A. Qualifications for all professional and non-professional disciplines. B. Staff conduct which must foster resident safety and well-being and must not be detrimental to resident care. C. Staff training, appropriate to staff responsibilities, including, at a minimum, an orientation and an on-going, but at least annual, program which includes: Fire Safety, First Aid, Safe Food Handling practices, Confidentiality of Records and Resident Information, Infection Control, Resident Rights, Reporting Requirements for Abuse, Neglect, and Exploitation, Transportation Safety for Assisting residents and operating vehicles to transport residents and Providing Quality Resident Care based on current resident needs. D. Employee personnel records, including an application for employment, TB tests and certificates, training records, and personnel actions. [4-7-97; 7.8.2.17 NMAC - Rn & A, 7 NMAC 8.2.17, 8-31-00] This REQUIREMENT is not met as evidenced by: BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE DOCUMENTATION OF STAFF ORIENTATION AND ONGOING TRAINING FOR 4 OF 7 STAFF. RECORD REVIEW ON 12/19/06 THROUGH 12/20/06 OF 7 STAFF FILES REVEALED NO DOCUMENTATION OF REQUIRED	A17	A17 Staff trainings will be conducted and do documented in each employees file rather than in one training note book as it is currently. This will include orientations, and staff trainings appropriate to staff responsibilities. Director will reviewaall staff files quarterly and schedule specific trainings that have not yet been conducted. All new hires will be processed including orientation before the 1st day of employment.	1-12-07

Scanned 1/11/07 JL

Division of Health Improvement

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JAN 10 2007

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director — (X6) DATE: 1/9/07

STATE FORM J16L11 — If continuation sheet 1 of 33

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A17	Continued From page 1 ORIENTATION AND ONGOING TRAINING FOR STAFF S-14, S-15, S-16, & S-17. DURING AN INTERVIEW WITH THE DIRECTOR ON 12/19/06 AT 3:30 PM THE DIRECTOR ACKNOWLEDGED THERE IS NO DOCUMENTATION OF TRAININGS FOR STAFF S-14 AND ON 12/20/06 AT 1:30 PM THE DIRECTOR ACKNOWLEDGED THERE IS NO DOCUMENTATION OF TRAININGS FOR STAFF S-15, S-16, & S-17.	A17		
A19	7 NMAC 8.2.19 ADMISSIONS 7.8.2.19 ADMISSIONS: No resident shall be admitted or retained who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. EXCEPTION: Maternity Shelters may accept residents below the age of eighteen (18). A. ADMISSION INTERVIEW. The Director of the facility or a designee responsible for admission and retention decisions, shall meet with the resident or the resident's agent or guardian, if the resident lacks decision-making capacity, and shall provide the resident with: (1) The facility's program narrative. (2) The facility's rules. (3) The facility's admission agreement, including costs and charges, refund provision, and contract termination policies. (4) The facility's bed hold policy. (5) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (6) A written description of the legal rights of the residents translated into another language, if necessary. (7) The facility's staffing pattern.	A19	A19 1-19-07 Admission/Retention meetings will be conducted for any resi resident who may require greater care than the facility normally provides, to include residentsawho may need Hospice care, temporary nusing care, etc. Director will re-review charts of residents currently recieving Hospice care or Nursing and schedule Team Meetings and notify Licensing Authority in writ-ing. These Team Meetings will be con conducted when any resident has a significant change in condition or ability.	

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A19	Continued From page 2 B. RESTRICTIONS ON ADMISSIONS: Adult residential care facilities shall not admit or retain individuals requiring continuous nursing care. Conditions or circumstances that usually require continuous nursing care, may include, but not limited to the following: (1) Ventilator dependency. (2) Pressure sores where skin loss penetrates beyond the skin, and into deeper tissue or bone, which are classified as Stage III or IV. (3) Intravenous therapy or injections directly into the vein. (4) Airborne infectious disease, in a communicable state, including tuberculosis, but excluding infections such as the common cold. (5) Any condition requiring either physical or chemical restraints. (6) Nasogastric tubes / gastric tubes. (7) Tracheostomy care. (8) Individuals presenting an imminent physical threat or danger to self or others. (9) Individuals whose physician certifies that placement is no longer appropriate. C. ADMISSION/RETENTION EXCEPTIONS: If a resident requires a greater degree of care than the facility would normally provide, or is permitted to provide, and the resident wishes to be re-admitted or to remain in the facility, and the facility wishes to re-admit or retain the resident, the facility must: (1) Convene a team, comprised of: (a) The facility director. (b) The resident. (c) The resident's agent, guardian or surrogate decision maker. (d) The resident's advocate, such as the resident's case manager, Ombudsman, or social worker. (e) If the treating physician is unable to	A19		

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A19	Continued From page 3 meet with the team, then consultation and recommendations via phone is acceptable. (f) Other appropriate health care professionals. (2) The team shall jointly determine if the resident should be admitted or allowed to remain in the facility. The team must approve a individual service plan that meets the specific needs of the resident. Such team approval must be in writing, signed and dated by all team members, must be maintained in the resident's record, and must: (a) Be based upon a individual service plan which identifies the resident's specific needs and addresses the manner that such needs will be met. (b) Ensure that the facility has and will maintain an evacuation rating of prompt or slow as determined by the Fire Safety Equivalency System (FSES). (c) Be based upon an assessment of the health, safety and well-being of the other facility residents. (d) Assess the impact that meeting the specific needs of the resident as set out in the individual service plan will have on the staff and on the other residents. (3) Notify the Licensing Authority within five (5) days of the completion of team approval. Such notification of team approval must be submitted in writing and include evidence of the team's consideration of items 7.8.2.19C2(a) through 7.8.2.19C2(d) above. [9-24-76, 7-11-86, 1-11-90, 4-7-97;7.8.2.19 NMAC - Rn. 7 NMAC 8.2.19, 8-31-00] This REQUIREMENT is not met as evidenced by: BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO NOTIFY	A19		

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A19	Continued From page 4 LICENSING AUTHORITY OF ADMISSION/RETENTION OF RESIDENTS RECIEVING A GREATER DEGREE OF CARE THAN THE FACILITY NORMALLY PROVIDES FOR 4 OF 5 RESIDENTS (R-2, R-3, R-4, R-9, & R-10). RECORD REVIEW ON 12/18/06 REVEALED NO DOCUMENTATION OF LICENSING AUTHORITY NOTIFICATION FOR 3 RESIDENTS (R2, R-3, & R-4) RECIEVING HOSPICE SERVICES AND 1 RESIDENT (R-9) RECIEVING HOME HEALTH SERVICES. DURING AN INTERVIEW WITH THE DIRECTOR ON 12/18/06 AT 3:00 PM, THE DIRECTOR STATED THAT SHE WAS UNAWARE THAT LICENSING AUTHORITY NOTIFICATION WAS REQUIRED.	A19		
A22	7 NMAC 8.2.22 RESIDENT RECORDS 7.8.2.22 RESIDENT RECORDS: A. RESIDENT RECORDS, CONTENTS: A record for each resident shall be maintained with specific information required. Entries in each resident's record shall be legible, dated, and authenticated by the signature of the person making the entry. Resident records must include: (1) Admission records as set out in Section 7.8.2.21 NMAC: (2) Within five (5) days of admission: (a) An executed admission agreement. (b) A completed resident assessment form. (c) Any available, admission physical examination report by a licensed health care professional, which may include all discharge information from another facility. When admission follows within thirty (30) days discharge from an	A22	A22 All staff entering any information in a residents chart will require a signature in the Caregiver Notes. An in-service has been conducted for staff and they have been given a copy of this regulation. Director will maintain and review caregiver notes monthly. Cont.	1-3-07

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A22	Continued From page 5 acute care hospital, the hospital history and physical report, and the hospital discharge summary may serve as an admission physical. (d) Names, addresses, relationship, and phone numbers of family members, and where appropriate, guardians, agents, and any surrogate decision makers. (3) Within thirty (30) days of admission: (a) A admission physical examination report by a licensed health care professional if an examination report was not available within five (5) days of admission. (b) Resident's name, age, recent photograph, social security number, marital status, date of birth, sex, address prior to admission, religion (optional), personal physician, dentist, social history and designated representative or other emergency contact person, language spoken and understood, legal documentation relevant to commitment and/or guardianship status, present medications, and diet required. (c) Any amendments to the admission agreement. (d) The current completed resident assessment form. (e) A completed and current individual service plan. (f) Entries by direct care staff, appropriate health care professionals, or others authorized to care for the resident. Entries shall be dated and signed by the person making the entry and shall include significant information related to the individual service plan. (g) Entries providing a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention, and	A22	A22 Cont. The signatures will begin with filing and any entries as of 1-1-07 A22 2. All residents charts will be reviewed to make sure current Individual Service Plans are on file. Case Managers will be contacted and a copy of the ISP will be requested for each D&E Waiver resident. The facility nurse will keep all ISP's up to date and the Director will oversee that this is done. All new residents will have their ISP completed within 5 days of admission.	1-19-07

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A22	Continued From page 6 entries reflecting appropriate follow-up. The maintenance of such written record in the resident record may be by copy of an incident/accident report, if the original incident/accident report is maintained elsewhere by the facility. (h) A medication record: Medications administered by licensed personnel and/or staff assisting with medications to include: listing all currently ordered medications by name, dosage, administration times; documenting by medication name, dosage, date, and time, each medication administered, with the initials of the individual who administered or assisted with the medication; documentation of errors, omissions, and side-effects of medications; and written consent by resident or guardian for staff to assisting with medications. (i) Date, time and progress note of health services provided by any contract agency. (j) Unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures. (k) Transfer forms completed, signed, and provided to accepting facility when resident is transferring to a hospital or another health care facility. (l) Documentation of disposition of the resident's personal effects and money or valuables deposited with the adult residential care facility, upon death or transfer. B. RESIDENT RECORDS, MAINTENANCE: (1) Resident records shall be maintained and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy for maintaining, and confidentiality of resident	A22		

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A22	Continued From page 7 records, including the authorized release of resident records. (3) Resident records must be maintained by the facility against loss, destruction, and unauthorized use for a period of not less than three (3) years from the date of discharge. (4) There must be a policy and procedure in place for record retention in the event of facility closure. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 7.8.2.22 NMAC - Rn 7 NMAC 8.2.22, 8-31-00] This REQUIREMENT is not met as evidenced by: 1. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE STAFF SIGNATURES ON ENTRIES IN RESIDENT'S CHARTS FOR 7 OF 8 RESIDENTS' (R-1, R-2, R-3, R-4, R-5, R-6, R-7, & R-8). (a) RECORD REVIEW OF RESIDENTS' CHARTS ON 12/18/06 THROUGH 12/19/06 REVEALED ENTRIES WITH NO SIGNATURES OF THE PERSON MAKING THE ENTRY ON THE "CAREGIVER NOTES" FOR RESIDENTS' R-2, R-3, R-4, R-5, R-6, R-7, & R-8. (b) DURING INTERVIEW WITH THE DIRECTOR ON 12/26/06 AT 11:00 AM, THE DIRECTOR ACKNOWLEDGED THE ENTRIES WERE NOT SIGNED. 2. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE CURRENT INDIVIDUAL SERVICE PLANS ON FILE FOR 5 OF 10 RESIDENTS	A22		

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A22	Continued From page 8 (a) RECORD REVIEW OF RESIDENT FILES ON 12/18/06 THROUGH 12/19-06 REVEALED NO CURRENT INDIVIDUAL SERVICE PLAN FOR RESIDENTS R-1, R-4, R-7, R-8, & R-9. (b) DURING AN INTERVIEW ON 12/19/06 AT 8:00 AM, THE DIRECTOR ACKNOWLEDGED THAT THE CURRENT INDIVIDUAL SERVICE PLANS WERE NOT ON FILE.	A22		
A23	7 NMAC 8.2.23 FAC. REPORTS,RECS.,P & PS & RULES 7.8.2.23 FACILITY REPORTS/RECORDS/POLICIES AND PROCEDURES/ AND RULES: A. REPORTS AND RECORDS: Each facility must keep the following reports, records, and policy and procedures on file at the facility and make them available for review upon request of the Licensing Authority: (1) Fire Inspection Report. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have fire inspection reports. (2) Copy of the last survey conducted by the Licensing Authority, adverse actions or appeals thereto, and complaints. (3) Copy of the latest survey from Environmental Health Authority (if applicable) regarding kitchen and food management and, if private sewage disposal, and private waste disposal. EXCEPTIONS: Adult residential care facilities with three (3) or fewer residents are not required to be inspected by Environmental Health Authority. Facilities exempted by the Environmental Health Authority having jurisdiction, are not required to have a survey on file provided the exemption letter is on file.	A23		

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A23	Continued From page 9 (4) TB test results of staff or any of their family members living in the facility. (5) One (1) month of menus planned and as served. (6) Record of fire drills: A record of all fire drills conducted at the facility. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to hold or record fire drills. (7) Written emergency plans and policies and procedures for medical emergencies, power failure, fire or natural disaster. Such plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes and refuge areas, responsibilities of personnel. (8) Licensing regulations: A copy of these regulations (Requirements for Adult Residential Care Facilities, 7.8.2 NMAC). (9) Custodial Drug Permit: A valid Custodial Drug Permit issued by the State Board of Pharmacy for those facilities licensed pursuant to these regulations. EXCEPTION: Adult residential care facilities with only one (1) resident are not required to have a custodial drug permit. (10) Vaccination of pets in the facility. (11) Staff training. (a) At orientation and on-going. (b) Appropriate to staff responsibilities. (Assistance with medications, dietary, environmental...) (c) Fire safety. (d) First aid. (e) Safe food handling practices. (f) Confidentiality of records and resident information. (g) Infection control (including universal precautions and linen handling). (h) Resident rights. (i) Providing Quality Resident care	A23		

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A23	Continued From page 10 based on current resident need. (j) Reporting requirements for Abuse, Neglect or Exploitation. (12) A copy of License. (13) Employee personnel records, including an application for employment, TB certificates, training records, and personnel actions. (14) A copy of all WAIVERS/VARIANCES granted by the Licensing Authority. (15) A copy of the floor plans as approved for licensure. B. RULES: Prior to placement in or admission to a facility, a prospective resident or his/her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to but not limited to the following: (1) The use of tobacco and alcohol. (2) The use of the telephone. (3) Operation of television, radio, and stereo. (5) Use and safekeeping of personal property. (6) Meals. (7) Use of common areas. (8) Electric blankets or appliances used by residents. C. POLICIES AND PROCEDURES: All facilities shall have written policies and procedures covering the following areas: (1) Actions to be taken in case of accidents or emergencies, (e.g., gas leaks, injuries, transportation, medications,...). (2) Method of keeping informed when residents go outside of the facility (e.g., sign-out sheets). (3) The handling or resident's funds, if the facility provides such services. (4) Reporting of incidents, including abuse, neglect, and exploitation.	A23		

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A23	Continued From page 11 (5) Handling of complaints. (6) Staff and resident fire and safety training. (7) Smoking. (8) The facility's bed hold policy. (9) Admission agreement. (10) Admission records. (11) Resident records. (12) Program Narrative. (13) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (14) Personnel policies. (15) Identifying and safeguarding resident possessions. (16) Securing medical assistance if a resident's own physician is not available. (17) NOTE FOR MATERNITY SHELTERS ONLY: In addition to the required policy and procedure topics listed above, Maternity Shelters shall have written policies and procedures regarding infant formula, feeding and equipment, and laundering of infant linen and diapers. (18) Staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles. (19) Staff training for employees who operate motor vehicles to transport residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.23 NMAC - Rn & A 7 NMAC 8.2.23, 8-31-00] This REQUIREMENT is not met as evidenced by: 1. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE DOCUMENTATION OF AN APPROVED VARIANCE FROM LICENSING AUTHORITY TO OPERATE TWO SEPARATE STRUCTURES	A23	A23 1. A copy of the approval letter from Frank White, Life Safety Code Surveyor has been obtained. This letter states that an increase of capacity has been approved. Director of Operations has a call in to Rita Meeks in Santa Fe regarding any other documentation of variance we should have that we do not have. Copy of letter from Frank White attached.	1-26-07

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	5772	A. BUILDING _____ B. WING _____	12/27/2006

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A23	Continued From page 12 UNDER 1 LICENSE. (a) DURING RECORD REVIEW ON 12/18/06, NO DOCUMENTATION OF A VARIANCE FROM LICENSING AUTHORITY WAS OBSERVED. (b) IN AN INTERVIEW WITH DIRECTOR ON 12/18/06 AT 1:40 PM, THE DIRECTOR ACKNOWLEDGED THERE IS ONE LICENSE FOR BOTH BUILDINGS AND DID NOT KNOW IF THERE WAS DOCUMENTATION OF A VARIANCE. 2. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE DOCUMENTATION OF STAFF ORIENTATION AND ONGOING TRAINING FOR 4 OF 7 STAFF (S-11, S-12, S-13, S-14, S-15, S-16, & S-17). (a) RECORD REVIEW ON 12/19/06 THROUGH 12/20/06 OF 7 STAFF FILES REVEALED NO DOCUMENTATION OF REQUIRED ORIENTATION AND ONGOING TRAINING FOR STAFF S-14, S-15, S-16, & S-17. (b) DURING AN INTERVIEW WITH THE DIRECTOR ON 12/19/06 AT 3:30 PM THE DIRECTOR ACKNOWLEDGED THERE IS NO DOCUMENTATION OF TRAININGS FOR STAFF S-14 AND ON 12/20/06 AT 1:30 PM THE DIRECTOR ACKNOWLEDGED THERE IS NO DOCUMENTATION OF TRAININGS FOR STAFF S-15, S-16, & S-17.	A23	A23 2. Documentation of on going trainings will be converted from a seperate file into employees file. Staff trainings will be conducted and documented in each employees file, to include orientations and staff training appropriate to staff responsibilities. Director will review all staff files quarterly and schedule specific trainigs that have not yet been conducted.	1-12-07
A26	7 NMAC 8.2.26 RESIDENT ASSESSMENT 7.8.2.26 RESIDENT ASSESSMENT: A. A resident assessment to determine level of function and if the client's needs can be met by	A26	All new hires will be processed including orientaion before the 1st day of employment.	

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A26	Continued From page 13 the facility. The initial assessment must be completed within five (5) days of admission and reviewed every six (6) months as part of the individual service plan. B. The resident assessment must establish a baseline in the resident's functional status and thereafter, identify resident changes through periodic reassessments. C. The resident assessment must be documented on a state approved resident assessment form and at a minimum include the following: (1) Cognitive patterns. (2) Communication/hearing patterns. (3) Vision patterns. (4) Physical functioning and structural problems. (5) Continence. (6) Psycho social well-being. (7) Mood and behavior patterns. (8) Activity pursuit patterns. (9) Disease diagnoses. (10) Health conditions. (11) Oral/nutritional status. (12) Oral/dental status. (13) Skin conditions. (14) Medication use. (15) Special treatment and procedures. D. The resident admission assessment, the physical exam report, and the observation and evaluation of staff with regards to the needs will be used to develop the individual service plan, if needed. If the resident assessment does not indicate a need for an individual service plan, then an individual service plan is not required. However, an individual service plan must be prepared for residents requiring nursing services. [4-7-97; 7.8.2.26 NMAC - Rn, 7 NMAC 8.2.26, 8-31-00] This REQUIREMENT is not met as evidenced	A26		

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A26	Continued From page 14 by: BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE A CURRENT ASSESMENT FOR 1 OF 10 RESIDENTS. RECORD REVIEW ON 12/19/06 REVEALED ONLY ONE ASSESSMENT DATED 2/20/06 FOR RESIDENT R-3. DURING AN INTERVIEW WITH THE DIRECTOR ON 12/18/06 AT 8:00 AM, THE DIRECTOR ACKNOWLEDGED THE ASSESSMENT FOR RESIDENT R-3 WAS NOT CURRENT.	A26	A26 All resident charts will be reviewed for current Assesments. The 1 Resident that did not have the completed assesment was completed on 12-28-06. Director will ensure all residents assesments are completed upon admission within 5 days and every 6mo. therafter. A list of the scheduled assesments will be typed and posted in the office and the nurse will also obtain a copy. This will be updated with every new resident. Director will continue to review charts and update assesments.	1-11-07 1-5-07
A27	7 NMAC 8.2.27 INDIVIDUAL SERVICE PLAN 7.8.2.27 INDIVIDUAL SERVICE PLAN: A. An individual service plan, if prompted by the resident assessment, shall be developed and implemented within fourteen (14) days of admission, and must address those areas of need as identified in the resident assessment. The individual service plan must be reviewed by a licensed nurse at least every six (6) months, and revised as needed at the time of each assessment and consistently implemented in response to the resident's needs. B. The individual service plan must include the following: (1) Description of identified needs as noted in the resident assessment. (2) Written description of what services will be provided. (3) Who will provide the services. (4) When or how often the services will be provided. (5) How the services will be provided. (6) Where the services will be provided.	A27		

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A27	Continued From page 15 (7) Goal and outcome of the service. (8) Documentation of the facility's determination that it is able to meet the needs of the resident.. [7-11-86, 1-11-90, 4-7-97; 7.8.2.27 NMAC - Rn, 7 NMAC.8.2.27, 8-31-00] This REQUIREMENT is not met as evidenced by: 1. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE CURRENT INDIVIDUAL SERVICE PLANS ON FILE FOR 5 OF 10 RESIDENTS (a) RECORD REVIEW OF RESIDENT FILES ON 12/18/06 THROUGH 12/19-06 REVEALED NO CURRENT INDIVIDUAL SERVICE PLAN FOR RESIDENTS R-1, R-4, R-7, R-8, & R-9. (b) DURING AN INTERVIEW ON 12/19/06 AT 8:00 AM, THE DIRECTOR ACKNOWLEDGED THAT THE CURRENT INDIVIDUAL SERVICE PLANS WERE NOT ON FILE.	A27	A27 Director will review all charts of D&E Waiver residents to ensure they have a current ISP. For those who do not the case manager will be notified to obtain a copy for the chart. The charts will be reviwed every 6 months to ensure all ISP's are kept up to date.	1-11-07
A33	7 NMAC 8.2.33 REPORTING OF INCIDENTS 7.8.2.33 REPORTING OF INCIDENTS: A. The facility must insure that all suspected cases or known incidents of resident abuse, neglect, exploitation, and mistreatment are reported. A facility must 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 and Adult Protective Services (APS) by the next business day. In no instance may a facility delay a report to Adult Protective Services or to the Licensing Authority, while an internal investigation is being conducted. B. The facility is responsible for documenting all incidents, within five (5) days of	A33	A33 When emergency services are contacted for a resident the director will complete an incident report and notify Licensing Authority via fax. Incident on 12-26-06 when emergency services were called and resident was transported to hospital has been reported and incident Cont.	1_2_07

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A33	Continued From page 16 the incident, and having on file, the following: (1) A narrative description of the incident. (2) Results of the facility's investigation. (3) The facility action, if any. [7-1-64, 9-15-70, 5-26-72, 7-11-86, 4-7-97; 7.8.2.33 NMAC - Rn 7 NMAC 8.2.33, 8-31-00] This REQUIREMENT is not met as evidenced by: BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO REPORT TO THE LICENSING AUTHORITY 2 INCIDENTS REQUIRING EMERGENCY SERVICES RESULTING IN ADMISSION TO THE HOSPITAL (7.1.13 NMAC). RECORD REVIEW ON 12/27/06 REVEALED RESIDENT R-9 WAS TRANSPORTED BY AMBULANCE FROM THE FACILITY TO THE HOSPITAL ON 11/24/06 AND AGAIN ON 12/8/06 WITH NO DOCUMENTATION OF AN INCIDENT REPORT. DURING AN INTERVIEW WITH THE DIRECTOR ON 12/26/06 AT 1:10 PM, THE DIRECTOR ACKNOWLEDGED INCIDENT REPORTS WERE NOT BEING DONE BY THE FACILITY FOR EMERGENCY SERVICES AND ADMISSION TO THE HOSPITAL.	A33	A33 Cont. report is in residents chart. Staff will also be in-serviced on incident reports and the completion procedure Director will review and ensure the incident reports are completed and reported to Licensing Authority.	1-2-07
A38	7 NMAC 8.2.38 FOOD MANAGEMENT 7.8.2.38 FOOD MANAGEMENT: Each facility must store, prepare, distribute and serve food under sanitary conditions and in accordance with the New Mexico Environment Department Food Service and Processor Regulations, if applicable. A. Each facility shall ensure a minimum of a three (3) day supply of perishable and a five (5) day supply of non-perishable or canned food is	A38		

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A38	Continued From page 17 provided for the residents. B. All milk, to include dry milk products, shall be Grade A pasteurized. C. Potentially hazardous food such as meat, milk, and custard shall be kept at 45 degrees F or below or at 140 degrees F or above. D. Each refrigerator and freezer shall be provided with an indicating thermometer accurate to plus or minus 3 degrees F, located in the warmest section of the refrigeration facility and must be of such type and so situated that the thermometer can be easily read. Thermostats shall not be relied upon to maintain temperatures at correct levels in the absence of thermometers. The temperature of the refrigerator shall be 35 degrees F- 45 degrees F. Freezer temperatures shall be maintained at 0 degrees F or below. E. Refrigerators, freezers, kitchen area and food preparation areas shall be kept clean and sanitary at all times. Food stored in refrigerators/freezers shall be covered, dated, and labeled. Unused leftover food shall be discarded after three days. F. Medication, biological, poisons, detergents, and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications may be stored in the refrigerator with food, if they are labeled and locked in a container marked specifically for medication. G. Dishes, utensils, and preparation equipment shall be properly washed and stored to maintain sanitary conditions. H. All garbage and rubbish shall be stored in containers which are waterproof, easily cleaned and have tight fitting lids. Food waste containers shall be kept in good repair, and shall be kept covered except during use. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 4-7-97; 7.8.2.38 NMAC - Rn, 7 NMAC 8.2.38,	A38	A38 All foods in the refrigerator will be labeled properly and in view. Director will monitor evry 3 days to ensure proper labeling and provide appropriate labeling equipment.	12-18-06

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A38	Continued From page 18 8-31-00] This REQUIREMENT is not met as evidenced by: 1. BASED ON OBSERVATION AND INTERVIEW THE FACILITY FAILED TO LABEL AND DATE 2 OF 5 FOODS OBSERVED IN THE REFRIGERATOR. (a) DURING TOUR OF THE FACILITY ON 12/18/06, FIVE FOOD CONTAINERS WERE EXAMINED IN THE REFRIGERATOR. A PARTIALLY USED CONTAINER OF DICED GREEN CHILE AND BACON WRAPPED IN FOIL WERE NOT LABELED OR DATED. (b) IN AN INTERVIEW WITH STAFF (S-11) ON 12/18/06 AT 1:10 PM, STAFF S-11 ACKNOWLEDGED SHE COULD NOT FIND ANY LABELS OR DATES ON THE TWO FOODS. 2. BASED ON OBSERVATION AND INTERVIEW THE FACILITY FAILED TO HAVE A TIGHT FITTING LID FOR THE FOOD WASTE CONTAINER IN THE KITCHEN. (a) DURING A TOUR OF THE FACILITY ON 12/18/06, THE FOOD WASTE CONTAINER LID WAS OBSERVED ON THE FLOOR WITH THE CLOSER FLAP GONE AND AN A GAPPING HOLE AT THE CORNER OF THE LID. (b) IN AN INTERVIEW WITH STAFF S-11 ON 12/18/06 AT 1:30 PM, STAFF S-11 ACKNOWLEDGED THE LID IS BROKEN.	A38	A38 2. 1-2-07 The kitchen staff will ensure a proper food waste container is provided in the kitchen. Any broken items will be reported to the Director and replaced Kitchen staff will not put the food waste container lid on the floor. Directir will monitor for proper use and condition.	
A40	7 NMAC 8.2.40 CAPACITY OF BUILDING(S)	A40		

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A40	Continued From page 19 7.8.2.40 CAPACITY OF BUILDING(S): A. A facility is not limited to the maximum number of residents if the building is built in accordance with the New Mexico Building Code, Uniform Building Code and National Fire Protection Associations NFPA 101(Life Safety Code). Appropriate building and fire code requirements for large facilities will be outlined during the plan review phase of the initial licensure process. Facilities with three (3) or fewer residents are exempt from certain building requirements; exemptions are identified within these regulations. B. All buildings on the premises housing residents will be considered part of the facility and must meet all requirements of these regulations. Buildings on the grounds of the licensed facility that are used by the residents of the facility will also be subject for inspection for health and safety standards. Each individual dwelling unit on the premises will be separately licensed. All rooms within licensed buildings are subject to inspection for health and safety standards. [7-1-64, 9-15-70, 5-26-72, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.40 NMAC - Rn, 7 NMAC 8.2.40, 8-31-00] This REQUIREMENT is not met as evidenced by: BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE DOCUMENTATION OF AN APPROVED VARIANCE FROM LICENSING AUTHORITY TO OPERATE TWO SEPARATE STRUCTURES UNDER 1 LICENSE. (a) DURING RECORD REVIEW ON 12/18/06, NO DOCUMENTATION OF A VARIANCE FROM LICENSING AUTHORITY WAS OBSERVED. (b) IN AN INTERVIEW WITH DIRECTOR ON	A40		

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A40	Continued From page 20 12/18/06 AT 1:40 PM, THE DIRECTOR ACKNOWLEDGED THERE IS ONE LICENSE FOR BOTH BUILDINGS AND DID NOT KNOW IF THERE WAS DOCUMENTATION OF A VARIANCE.	A40		
A43	7 NMAC 8.2.43 MAINTENANCE OF BUILDING AND GROUNDS 7.8.2.43 MAINTENANCE OF BUILDING AND GROUNDS: The building(s) must be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following: A. All electrical, fire protection signaling, mechanical, telephone, water supply, heating, fire protection, and sewage disposal systems maintained in a safe and functioning condition, including regular inspections of these systems, (as applicable). B. The building, furniture and furnishings, storage areas, and grounds of the facility must be maintained in a safe, sanitary, and presentable condition at all times. C. Storage areas must be kept free from accumulation of refuse, discarded furniture, old newspapers, that create a fire hazard. D. Floors shall be maintained stable, firm, slip-resistant and free of tripping hazards. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.43 NMAC - Rn, 7 NMAC 8.2.43, 8-31-00] This REQUIREMENT is not met as evidenced by: 1. BASED ON OBSERVATION AND INTERVIEW THE FACILITY FAILED TO MAINTAIN THE BUILDING AND GROUNDS IN GOOD REPAIR. (a) DURING TOUR OF THE FACILITY ON 12/26/06, IT WAS OBSERVED THAT EMPLOYEE BATHROOM, ROOM # 17,	A43	A43 1. A maintenance request was ordered on 12-26-06 in regards to the broken window in the staff bathroom. Window was replaced on 12-27-06 All broken items in need of repair will continue to be reorted to maintenance for repair and Director will follow up weekly until complete.	12-27-06

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A43	Continued From page 21 BUILDING 1, HAD A BROKEN WINDOW GLASS. (b) DURING AN INTERVIEW WITH THE DIRECTOR ON 12/27/06 AT 9:00AM, THE DIRECTOR ACKNOWLEDGED THE WINDOW IS BROKEN. (c) DURING A TOUR OF THE FACILITY ON 12/26/06, A SMALL CINDERBLOCK STRUCTURE WITH A ROTTEN PLYWOOD TOP AND BIO-HAZARD SIGNS ON IT WAS OBSERVED ON THE GROUNDS. (d) IN AN INTERVIEW WITH THE DIRECTOR AND MAINTENANCE STAFF ON 12/26/06, THE DIRECTOR AND THE MAINTENANCE STAFF BOTH ACKNOWLEDGED THE STRUCTURE IS LOCKED AND THE CONTENTS OF THE STRUCTURE IS UNKNOWN.	A43	A43 Cont. The facility Med Waste company will be contacted to investigate the contents in the cinder block structure. Med Rid will arrive to package up any items that are in the structure. Steri Cycle will then remove and transport any materials to be disposed of. Upon approval and having approval in writing, Maintenance will destroy and remove the structure.	1-10-07 1-25-07
A45	7 NMAC 8.2.45 HEATING, VENTILATION AND AIR-CONDITIONING 7.8.2.45 HEATING, VENTILATION AND AIR-CONDITIONING: A. Heating, air-conditioning, piping, boilers, and ventilation equipment must be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities must have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. B. The heating method used by the facility must provide a minimum temperature of seventy (70) degrees Fahrenheit in all rooms used by the residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating	A45		

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A45	Continued From page 22 device may be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances must be permanently anchored and kept away from flammables such as curtains, bedcoverings, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or danger from electrical shock. D. Fireplaces and open flame heating are not permitted to be utilized in sleeping rooms. E. Gas fired water heaters must not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms. F. A facility must be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means. G. All openings to the outside air used for ventilation must be screened for the control of insects and rodents. Screen doors must be equipped with self-closing devices. H. A facility must be provided with a system for maintaining residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard or danger from electrical shock. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7-1-64, 9-15-70 9-24-76, 7-11-86, 4-7-97;7.8.2.45 NMAC - Rn, 7 NMAC 8.2.45, 8-31-00] This REQUIREMENT is not met as evidenced by: BASED ON OBSERVATION INTERVIEW THE FACILITY FAILED TO INSURE OUTSIDE OPENINGS USED FOR VENTILATION ARE PROPERLY SCREENED. DURING TOUR OF THE FACILITY ON 12/26/06,	A45	A45 All outside openings used for ventilation will be equipped with proper screens. Director will monitor for any lose or missing screens on a daily basis. Any needed repairs or replacements will be reported Cont.	12-27-06

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	5772	A. BUILDING _____ B. WING _____	12/27/2006

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A45	Continued From page 23 IT WAS OBSERVED THAT THERE ARE NO SCREENS ON THE WINDOWS USED FOR VENTILATION TO RESIDENTS' ROOMS 15 AND 16 OF BUILDING 1. IN AN INTERVIEW WITH THE DIRECTOR ON 12/27/06 AT 8:45 AM, THE DIRECTOR ACKNOWLEDGED THE SCREENS WERE MISSING FOR RESIDENTS' ROOMS 15 AND 16 OF BUILDING 1.	A45	A45 Cont. to Maintenance and followed up weekly until completed.	
A46	7 NMAC 8.2.46 WATER 7.8.2.46 WATER: A. A facility must be provided with an adequate supply of water which is of a safe and sanitary quality suitable for domestic use. Hot and cold running water under pressure must be distributed to all food preparation areas, lavatories, washrooms, and laundries. B. If the water supply is not obtained from an approved public system, the private water system must be inspected, tested, and approved by the Environmental Health Authority prior to licensure. It is the facility's responsibility to insure that subsequent periodic testing or inspection of such private water systems be made at intervals as prescribed by the Environmental Authority. C. The hot water temperature accessible to residents must be maintained at a minimum of 95 degrees Fahrenheit and a maximum of 110 degrees Fahrenheit. Hot water in excess of 110 degrees Fahrenheit is permitted in kitchen and laundry areas, provided residents are supervised to prevent injury. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.46 NMAC - Rn, 7 NMAC 8.2.46, 8-31-00] This REQUIREMENT is not met as evidenced by:	A46	A46 12-28-06 Monthly Safety Inspections are conducted by the Director, to include testing water temperatures. When the water temperature is not between 95 to 100 degees a maintenace request will be submitted for the temperature to be adjusted. Director will continue to monitor water temperatures monthly.	

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A46	Continued From page 24 BASED ON OBSERVATION INTERVIEW THE FACILITY FAILED TO MAINTAIN HOT WATER TEMPERATURE BETWEEN 95 DEGREES AND 110 DEGREES FAHRENHIET IN 1 OF 3 BATHROOMS. DURING TOUR OF THE FACILITY ON 12/20/06 THE HOT WATER TEMPERATURE IN THE SOUTH BATHROOM OF BUILDING 3 MEASURED 114.5 DEGREES FAHRENHIET. IN AN INTERVIEW WITH THE DIRECTOR ON 12/27/06 AT 9:00 AM, THE DIRECTOR STATED SHE WAS UNAWARE THE WATER TEMPERATURE WAS THAT HIGH.	A46		
A55	7 NMAC 8.2.55 RESIDENT ROOMS 7.8.2.55 RESIDENT ROOM: A. Each resident room must be an outside room with a window. The area of the outdoor window shall be at least 1/10th the floor area of the room. B. There must be no through traffic in resident rooms. C. Resident rooms must communicate directly with other areas of the facility. Toilet and bathing facilities must be located to meet the needs of the residents. D. Resident rooms may be private or semi-private. Semi-private rooms may not house more than two (2) residents. EXCEPTION: Facilities that provide programmatic services for alcohol or drug dependency on a short term (30-60 days) may have dormitories with no limitation on number of residents as long as minimum square footage requirements are met. (1) Private Rooms: must have a minimum of one hundred (100) square feet of floor area. Closet and locker area shall not be	A55	A55 A seperate closet area will be provided for each individual resident in semi provate rooms. When not present the Director will request from Maintenance an additional portable closet or a divider for the built in closet. Director will ensure all rooms have adequet closets for each resident.	12-28-06

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A55	Continued From page 25 counted as part of the available floor space. (2) Semi-Private Rooms: must have a minimum of eighty (80) square feet of floor area for each bed and be furnished in such a manner that the room is not crowded or passage out of the room is obstructed. Closet and locker area shall not be counted as part of the available floor space. (3) Dormitories/Wards: must have a minimum of sixty (60) square feet of floor area for each bed. Closet and locker area shall not be counted as part of the available floor space. E. If a resident chooses not to bring in his/her own furnishings, each resident room shall be provided with, as a minimum, the following per resident: F. Furnishings: (1) Resident beds shall be at least thirty-six (36) inches wide, of sturdy construction, and in good repair. (2) Each bed shall be provided with a clean, comfortable mattress of at least four (4) inches in thickness, which is waterproof, or protected with a waterproof covering, and a mattress pad. (3) Each bed shall be provided with a clean, comfortable pillow. (4) Each bed shall be provided with a pillow case, two (2) clean sheets, blankets, and a bedspread appropriate for the weather and climate. (5) Beds shall be spaced at least three (3) feet apart. (6) An individual closet or closet area with a clothes rack for hanging clothes and shelves or drawers that are accessible to the resident. (7) A bedside table or desk. (8) A chair. (9) A reading lamp.	A55		

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A55	Continued From page 26 (10) A mirror in the resident room. (11) Window shades, drapes, curtains, or blinds, in good repair and of flame-retardant materials. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.55 NMAC - Rn, 7 NMAC 8.2.55, 8-31-00] This REQUIREMENT is not met as evidenced by: BASED ON OBSERVATION AND INTERVIEW THE FACILITY FAILED TO PROVIDE A SEPARATE CLOSET AREA IN 1 OF 6 SEMI-PRIVATE ROOMS. DURING TOUR OF THE FACILITY ON 12/20/06, SEMI-PRIVATE ROOM 8 OF BUILDING 3 WAS OBSERVED TO HAVE ONLY ONE SHARED CLOSET. INTERVIEW WITH STAFF S-18 ON 12/20/06, STAFF S-18 ACKNOWLEDGED THE CLOSET IS SHARED.	A55		
A59	7 NMAC 8.2.59 FIRE CLEARANCE AND INSPECTIONS 7.8.2.59 FIRE CLEARANCE AND INSPECTIONS: A. Written documentation from the State Fire Marshall's office or Fire Prevention Authority having jurisdiction indicating a facility's compliance with applicable fire prevention codes shall be submitted to the Licensing Authority prior to issuance of a initial license. B. Each facility shall request from the local fire prevention authorities an annual fire inspection. If the policy of the local fire department does not provide for annual inspection of the facility, the facility will document the date the request was made and to whom and	A59	A59 1-4-07 The Director will request an inspection from the local Fire Department. The documentation of such inspection will be kept in the safely inspections log book. When the local Fire Department does not contact the facility Cont.	

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A59	Continued From page 27 then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility. [7-1-64, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.59 NMAC - Rn, 7 NMAC 8.2.59, 8-31-00] This REQUIREMENT is not met as evidenced by: BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY DID NOT REQUEST AN INSPECTION FROM THE LOCAL FIRE AUTHORITIES. DURING RECORD REVIEW ON 12/18/06, THERE WAS NO DOCUMENTATION OF REQUEST FOR INSPECTION BY LOCAL FIRE AUTHORITIES. DURING AN INTERVIEW WITH THE DIRECTOR ON 12/18/06 AT 1:55 PM, THE DIRECTOR STATED SHE HAD NO KNOWLEDGE OF A REQUEST FOR INSPECTION BY THE LOCAL FIRE AUTHORITIES.	A59	A59 cont. to schedule the inspections the Director will call to schedule the inspection annually. 1-9-07 Local Fire Dept. inspection. Copy of inspection attched. Fire alarm system not working. Request has been made for repair/replacement. --23-07	
A63	7 NMAC 8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING 7.8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff personnel of the facility must know the location of and be instructed in proper use of fire extinguishers and other procedures to 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	A63		

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A63	Continued From page 28 their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways, and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident must upon being accepted into the facility be given an orientation tour of the facility to include, but not be limited to, the location of the exits, fire extinguishers, and telephones, and shall be instructed in action to be taken in case of fire or other emergency. D. Fire Drills: The facility must conduct at least one (1) fire drill each month: (1) Fire drills must be held at different times of the day. (2) The fire alarm system or detector system in the facility shall be used in the conduct of fire drills. (3) In the conduct of fire drills, emphasis must be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of fire drills held must be maintained on file in the facility. Such record must show date and time of the drill, number of personnel participating in the drill, any problem noted during the drill and the evacuation time in total minutes. (5) The local fire department should be requested to supervise and participate in fire drills. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.63 NMAC - Rn, 7 NMAC 8.2.63, 8-31-00] This REQUIREMENT is not met as evidenced by: DURING RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO USE THE FIRE ALARM SYSTEM WHEN CONDUCTING FIRE	A63	A63 During monthly fire drills the alarm will be used to ensure proper working conditions. The Director will also request someone from the local Fire Dept. be present occasionally for fire drills. Director will ensure fire alarm is being used.	12-28-06

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A63	Continued From page 29 DRILLS. DURING RECORD REVIEW ON 12/18/06 OF THE MONTHLY FIRE DRILLS, THERE WAS NO DOCUMENTATION OF THE FIRE ALARM SYSTEM BEING UTILIZED TO CONDUCT MONTHLY FIRE DRILLS. DURING AN INTERVIEW WITH THE DIRECTOR ON 12/18/06 AT 2:00 PM, THE DIRECTOR ACKNOWLEDGE THE FIRE ALARM SYSTEM IS NOT USED TO CONDUCT MONTHLY FIRE DRILLS.	A63		
A66	7 NMAC 8.2.66 RELATED REGULATIONS AND CODES 7.8.2.66 RELATED REGULATIONS AND CODES: Adult residential care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96). B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96). C. Adjudicatory Hearings, New Mexico Department of Health, 7 NMAC 1.2 (2-1-96). [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.66 NMAC - Rn, 7 NMAC 8.2.66, 8-31-00] This REQUIREMENT is not met as evidenced by: 1. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE CAREGIVER CRIMINAL HISTORY SCREENING CLEARANCE FOR THE DIRECTOR OF THE FACILITY AND FOR 1 OF 7 STAFF (CAREGIVER CRIMINAL HISTORY	A66	A66 1. 1-2-07 Fingerprints for the Director will be completed and forwarded on to recieve the clearance letter. Fingerprints will also be completed for 1 staff member that was not yet complete. 12-20-06 Director will ensure that all staff fingerprints are completed prior to the first day of employment. This documentation will be put in the employees file. During the period before the clearance letter arrives, that staff member will not transport or be alone with any resident. A66 Cont.	

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A66	Continued From page 30 SCREENING 7.1.9 NMAC). (a) DURING RECORD REVIEW ON 12/20/06, THERE WAS NO DOCUMENTATION OF CAREGIVER CRIMINAL HISTORY SCREENING CLEARANCE OR DOCUMENTATION THAT FINGERPRINTS WERE SENT FOR STAFF S-15 WITH A HIRE DATE OF 8/9/06, OR FOR THE DIRECTOR OF THE FACILITY WITH A HIRE DATE OF 8/27/02. (b) DURING AN INTERVIEW WITH THE DIRECTOR ON 12/21/06 AT 8:30 AM, THE DIRECTOR ACKNOWLEDGED FINGERPRINTING HAD NEVER BEEN DONE FOR HERSELF OR FOR STAFF S-15. 2. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO SEND FINGERPRINTING WITHIN THE 20 DAYS FROM DATE OF HIRE FOR THE DIRECTOR AND FOR 2 OF 7 STAFF (CAREGIVER CRIMINAL HISTORY SCREENING 7.1.9.8.F NMAC). (a) RECORD REVIEW ON 12/19/06 REVEALED THAT STAFF S-15 WITH A HIRE DATE OF 8/9/06 HAD NO DOCUMENTATION OF FINGERPRINTING, STAFF S-17 WITH A HIRE DATE OF 5/16/06 FINGERPRINTS WERE SENT ON 8/29/06, AND FACILITY DIRECTOR WITH A HIRE DATE OF 8/27/02 HAD NO DOCUMENTATION OF FINGERPRINTING. (b) DURING AN INTERVIEW WITH THE DIRECTOR ON 12/21/06 AT 8:30 AM, THE DIRECTOR ACKNOWLEDGED FINGERPRINTING HAD NEVER BEEN DONE FOR HERSELF OR FOR STAFF S-15.	A66	1-22-07 A66 2. Fingerprints will be completed within the first 20 days from the date of hire. Direcor will ensure fingerprints are completed for all new hires within 20 days. Employee chart audits will be co conducted every 6 months to ensure all records are up to date.	

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A66	Continued From page 31 3. BASED ON RECORD REVIEW THE FACILITY FAILED TO INQUIRE WITH THE EMPLOYEE ABUSE REGISTRY BEFORE DATE OF HIRE FOR 3 OF 4 STAFF HIRED AFTER 1/1/06. (EMPLOYEE ABUSE REGISTRY 7.1.12.8.A) RECORD REVIEW ON 12/19/06 AND 12/20/06 REVEALED THAT STAFF S-15 WITH A HIRE DATE OF 8/9/06 WAS NOT CLEARED THROUGH THE EMPLOYEE ABUSE REGISTRY UNTIL 9/4/06, STAFF S-16 WITH A HIRE DATE OF 8/19/06 WAS NOT CLEARED THROUGH THE EMPLOYEE ABUSE REGISTRY UNTIL 9/4/06, AND STAFF S-17 WITH A HIRE DATE OF 5/16/06 WAS NOT CLEARED THROUGH THE EMPLOYEE ABUSE REGISTRY UNTIL 9/4/06. 4. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO REPORT TO THE LICENSING AUTHORITY 2 INCIDENTS REQUIRING EMERGENCY SERVICES RESULTING IN ADMISSION TO THE HOSPITAL (7.1.13 NMAC). (a) RECORD REVIEW ON 12/27/06 REVEALED RESIDENT R-9 WAS TRANSPORTED BY AMBULANCE FROM THE FACILITY TO THE HOSPITAL ON 11/24/06 AND AGAIN ON 12/8/06 WITH NO DOCUMENTATION OF AN INCIDENT REPORT. (b) DURING AN INTERVIEW WITH THE DIRECTOR ON 12/26/06 AT 1:10 PM, THE DIRECTOR ACKNOWLEDGED INCIDENT	A66	A66 3. Prior to date of hire all employees will be cleared through the Employee Abuse Registry. Director will review all employee charts who were hired after 1-1-06 to ensure the employee abuse registry has been completed and cleared. Director will ensure all new hires will be cleared through the Employee Abuse Registry prior employment. A66 4. When emergency services are contacted for a resident the Director will complete an incident report and notify Licensing Authority via fax. A66 4. Cont.	1-22-07 1-2-07

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A66	Continued From page 32 REPORTS WERE NOT BEING DONE BY THE FACILITY FOR EMERGENCY SERVICES AND ADMISSION TO THE HOSPITAL.	A66	A66 4. Incident on 12-26-06 when emergency services were called and the resident was transported to the hospital has been reported and the incident report isiin the chart. Staff will also be in-serviced on incident reports and the reporting procedure. Director will review and ensure the incident reports are completed and reported to Licensing Authority.	