STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2068	A. BUILDING _____ B. WING _____	C 06/03/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING	4308 TULANE DRIVE NE ALBUQUERQUE, NM 87107

ORIGINAL

(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
A22	7 NMAC 8.2.22 Resident Records 7.8.2.22 RESIDENT RECORDS: A. RESIDENT RECORDS, CONTENTS: A record for each resident shall be maintained with specific information required. Entries in each resident's record shall be legible, dated, and authenticated by the signature of the person making the entry. Resident records must include: (1) Admission records as set out in Section 7.8.2.21 NMAC: (2) Within five (5) days of admission: (a) An executed admission agreement. (b) A completed resident assessment form. (c) Any available, admission physical examination report by a licensed health care professional, which may include all discharge information from another facility. When admission follows within thirty (30) days discharge from an acute care hospital, the hospital history and physical report, and the hospital discharge 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	A22	RECEIVED SEP 0 2 2008	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sheila Delaloussaye

TITLE: Administrator

(X6) DATE: 8/25/2008

S. ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2068	A. BUILDING _____ B. WING _____	C 06/03/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING	4308 TULANE DRIVE NE ALBUQUERQUE, NM 87107

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A22	Continued From page 1	A22		

diet required.

(c) Any amendments to the admission agreement.

(d) The current completed resident assessment form.

(e) A completed and current individual service plan.

(f) Entries by direct care staff, appropriate health care professionals, or others authorized to care for the resident. Entries shall be dated and signed by the person making the entry and shall include significant information related to the individual service plan.

(g) Entries providing a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention, and entries reflecting appropriate follow-up. The maintenance of such written record in the 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

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TENDER HEART ASSISTED LIVING	4308 TULANE DRIVE NE ALBUQUERQUE, NM 87107

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A22	Continued From page 2 agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures. (k) Transfer forms completed, signed, and provided to accepting facility when resident is transferring to a hospital or another health care facility. (l) Documentation of disposition of the resident's personal effects and money or valuables deposited with the adult residential care facility, upon death or transfer. B. RESIDENT RECORDS, MAINTENANCE: (1) Resident records shall be maintained and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy for maintaining, and confidentiality of resident records, including the authorized release of resident records. (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: Surveyor: 26582 Refer to 7.8.2.22 B. (3) Based on record review and interview the facility failed to maintain and store resident records in an organized and accessible manner for a period of	A22		

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A22	Continued From page 3 not less than three (3) years from date of discharge for one of five sampled resident (#3) records. The findings are: A. On 6/3/08 during review of resident #3 ' ' s record with the facility administrator she stated there were no documents (Run Sheets or Transfer information) from EMS. She stated she believes the family retained this information. She also stated the 4/2008 Medication Administration Record (MAR), 911 Run Sheets and hospital paperwork were bundled and placed above the medication cart in the kitchen of the facility. " The reason the paper work is not there is due to possible stealing by disgruntled employees. "	A22	22 7 NMAC 7.8.2.33.B.(3) A. On June 3, 2008, during survey, Administrator went to retrieve records for surveyor which were found to be missing, which were the April MARs which had been stored in usual and customary location. For April 2008, the records contained incriminating information which were to be used in unemployment hearings to document misconduct. Fortunately, duplicate copies of some records had been made for the hearings and were available to document misconduct. Effectively immediately, new procedures have been implemented. First, at end of month, MARs are now archived in locked cabinet, and not accessible to employees. Second, only two individuals have keys to the locked file cabinet, thus providing a more secure location for records. Third, the amount of records stored on site at the facility have been reduced and a more secure offsite location is now used for long term storage. This should minimize theft and misappropriation of records. Facility retains all records as required by law, but does not have any control over theft or misappropriation of records, other than increasing security and lock-up requirements, as noted above.	
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 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]	A33		

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A33	Continued From page 4 This REQUIREMENT is not met as evidenced by: Surveyor: 26582 Refer to 7.8.2.33 B. Based on record review and interview the facility failed to report an incident in which a resident fell and sustained a pelvic fracture to the Licensing authority by the next business day. The facility also failed to provide documentation of the incident (within 5 days) and have on file: a narrative description of the incident, results of the facility investigation, and the facility action, if any, for one of 5 sampled resident's (resident #3). The findings are: A. On 6/3/08 review of closed record for sampled resident #1 admitted 6/16/07, no documentation was found that the resident had fallen. There was also no documentation to indicate a narrative with the description of the incident, results of the facility investigation or facility action was conducted. B. On 6/3/08 at 11:06 AM interview with Administrator stated in reference to Resident #3 ' s fall which occurred on grave yard shift. Her tag alarm went off and was found on the floor with her nose bleeding, 911 EMS was called. She also stated this fall was not reported, " shame on me, I should have reported it, it was when I was on duty " .	A33	7 NMAC 7.8.2.33 A. Upon investigation of this incident, staff on duty reported that 911 report had been prepared, but misplaced after incident while awaiting death record from hospice. In order to avoid failure of documentation in future, daily and weekly reviews are now held to ensure that all incidents have been reported and the required paperwork prepared in a timely manner. In addition to interviewing the staff, the Administrator reviews the records and reports for timeliness and completeness. This should eliminate/minimize the incomplete documentation. Administrator will file initial report, and conduct followup investigation as indicated which will include narrative description, results of investigation, and facility action, if any, focusing on corrective action plan going forward. B. Upon covering no-show graveyard shift, Administrator failed to file required 911 report, due to oversight. In order to ensure that this does not happen again, Administrator now conducts routine inquiries of staff on at least a daily and weekly basis, and more often as indicated, and reviews the records at least weekly to identify any missing documentation. If reports have not been completed, they are completed at that time and filed and/or faxed to DOH, as required. This should eliminate/minimize failure to complete documentation as required. Administrator will file initial report, and conduct followup investigation as indicated which will include narrative description, results of investigation, and facility action, if any, focusing on corrective action plan going forward.	