STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5883	A. BUILDING _____ B. WING _____	06/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTS THAT CARE ASSISTED LIVING, LLC	9977 BUCKEYE STREET NW ALBUQUERQUE, NM 87114

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A 01	OPENING REMARKS A complaint investigation was completed on 7/22/2009 for NMAC 7.8.2-New Mexico Regulations Governing Adult Residential Care Facilities. Intake # NM00027043 was Substantiated with deficiencies cited.	A 01	A. ~~Re~~training was done on 8/6/09 and an amendment was drafted for monitor (skin) form to include on it, to follow-up with an incident form and it is be filed appropiately. If Incident requires report to APS, APS will be called with 24hrs + written documentation will be filed ~~to case~~ with APS ~~for~~ to put in their database. B. Staff did an assessment to each Resident fall, staff filled out skin monitor form, Communicated in daily Communication Book for all residents Staff failed to follow-up with an incident report Staff will be retrained to reorient to proper documentation, Policies & Procedures & Regulations	
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] This Requirement is not met as evidenced by: Refers to 7.8.2.33A - Reporting of Incidents Based on record review and interviews, the facility failed to ensure that incidents or unusual occurrences that have or could threaten the health, safety or welfare of the residents were	A33		

Scanned 08-12-09

within 5 day

deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Owner	08-06-09

FORM CMS-2567(02-99) NSWZ11 If continuation sheet 1 of 8

RECEIVED
AUG 2009
HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

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A33	Continued From Page 1 reported as required for 75% of facility residents (Resident #1, Resident #2 and Resident #3). The findings are: A. On 6/23/09 during review of facility records, the following documentation was on file at the facility: -An undated Skin Monitoring sheet for Resident #3 indicating a fall had occured when this visually impaired resident attempted to walk unassisted. No documentation was available as to whether there was medical follow-up for this resident subsequent to this, a determination as to whether a facility investigation was conducted, any facility action subsequent to this incident. B. On 6/23/09 during review of facility records, the following documentation was on file at the facility: -A Skin Monitoring sheet dated 05/06/09 at 3:00 AM for Resident #1, comments noted that Resident #1 "she got to use the betrom and she fall at [sic] bet". Under Action Taken: caregiver documented that she "she ask [sic] if she ok. she [sic] ok [sic] I hep to get up." No documentation was available as to whether there was medical follow-up for this resident subsequent to this, a determination as to whether a facility investigation was conducted, any facility action subsequent to this incident. Review of Department of Health Incident Reporting system database on 6/23/09 and again on 7/22/09 revealed that none of that information was logged into the database showing that it had been reported, investigated or followed up on. -A Skin Monitoring sheet dated 06/04/09 at 11:30 AM for Resident #1, comments noted that Resident #1 [sic] "try to use the batrom ba she	A33	A. Staff will be retrained to the importance of followup on incident report and report to APS if needed. B. Staff did an assessment on Resident (#1) called Hospice right away. Hospice told staff to call 911. Staff was retrained on 8/6/09 to reinerate Follow-up on procedures for accurate documentation. An addendum to skin report form was drafted to remind staff to Fill out Incident Report. Follow through with all steps to report to appropriate agencies (APS) (B) Staff did an assess on 8/6/09 along with a Visiting Home Health Care	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A33	Continued From Page 2 feall bihay ta [sic] she open he (her) head". No documentation was available any facility action subsequent to this incident. Review of Department of Health Incident Reporting system database on 6/23/09 and again on 7/22/09 revealed that none of that information was logged into the database showing that it had been reported, investigated or followed up on. -A Skin Monitoring sheet dated 06/05/09 at 12:30 PM for Resident #1, comments noted that Resident #1 "she walk to the bathrom and she fall an te shower." Under Action Taken: caregiver documented that she "forget to call hospes". "I try to pek up bat I ask if she fieol ok." No documentation was available as to whether there was medical follow-up for this resident subsequent to this, a determination as to whether a facility investigation was conducted, any facility action subsequent to this incident. Review of Department of Health Incident Reporting system database revealed that none of that information was logged into the database on 6/23/09 and again on 7/22/09 showing that it had been reported, investigated or followed up on. C. On 6/23/09 during review of Incident Reports on this facility, incident report noted that in mid April 2009 during a visit to the facilty, Resident #2 was noted to have sustained a fracture of the left middle finger with unkown etiology. On 6/30/09 at 1:20 PM during Anonymous interview #12 interviewee states that during the process of caring for Resident #2 at this facility, it was discovered that Resident #2 had sustained a fracture of her left middle finger with unknown etiology. On 07/07/09 at 10:40 AM during a phone interview with Anonymous interviewee #6,	A33 5/6/09 6/5/09 C.	Professional (unknown) £ Skin Monitoring report was filled out, staff will be retrained to follow-up with Incident Report Form and report to APS, as necessary staff did an assessment helped resident (#1) up. staff will be retrained to follow-up on all policies and procedures to be documented and reported. Amended documents have be revised to ~~meet~~ remind staff step (next). Skin Monitoring Form will indicate step by step instructions. That will be signed + dated by all ~~there~~ Health Care Professional @ Facility. Resident #2 was Hospice Patient and bed bound. All paperwork →	

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A33	Continued From Page 3 interviewee states that she saw that Resident #2's hand was 'black'. Interviewee reports that it was later discovered that Resident #2 had had an X-Ray that indicated a fractured finger. No documentation was available as to whether a facility investigation was conducted regarding this incident, or whether any facility action was taken subsequent to this incident. Review of Department of Health Incident Reporting system database on 6/23/09 and again on 7/22/09 revealed that none of that information was logged into the database showing that it had been reported, investigated or followed up on. D. On 07/07/09 at 10:53 AM during interview with Department of Health Incident Management Staff, it was noted that there were no incident reports, late (past 24 hour required time frame) reports, facility investigation reports or follow up reports on the Department of Health database for any of the incidents involving Residents #1, #2 and #3.	A33	C was filled out by staff internally @ facility. Staff Failed to follow up on Incident Reporting Retraining will be Conducted by owner on 8/6/09. D. Owner will retrain staff to reorient them to all Forms available and to there where a-bouts. Staff will be informed of all changes to Policies + Procedures. Staff will Continue to get updates as they occur. A check list will be revised by owner @ inservice to verify #retraining + reorientation. -Staff retraining on 8/6/09 Steps to Complete process of proper reporting to APS (Paperwork)	
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	A36		

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A36	Continued From Page 4 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 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	A36	A. Staff cannot administer Medication @ the Facility, they can assiste Residents With medications. The Facility is a ~~Non-Nursing~~ Nonskilled Nursing Facility B. Staff will be retrained on Proper Filing of important documents. They will be instructed to look in filing cabinet and pull what ever records on file, for survey purposes C. Staff will get retraining on filing and to have all necessary paperwork available to surveyor. Owner Conducted Mock Survey on 8/6/09 and ~~we~~ check list was signed and dated by all in attendance D. Staff Will be reoriented to placement of all reference Material	

See Attached

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A36	Continued From Page 5 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 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(F)(8) - Medication Administration Record Based on record review and interview, the facility failed to ensure that the Medication Administration Record (MAR) was signed for each medication given to residents for 2 of 4 residents (Resident #2 and Resident #4). The findings are: A. On 06/23/09 during review of administrative records, it was noted that the MAR for February	A36	A. Plan of Action was drafted back in 2/09. ~~with~~ step by step instruction are on facility medicine cabinet door. Staff upon hiring, are trained and retrained ~~as need~~ as needed daily, weekly or whenever. H2 Staff was trained @ initial in-service upon hiring, and will receive retraining monthly, weekly or daily. A plan of Action was drafted on February 2009. Next training 8/6/09 I Staff was trained to report and ~~was~~ all errors to supervisor Physician or Pharmacy, for any Medication errors. J. Staff has all proper Paperwork on file (written) Policy and Procedures. Staff will be retrained to record all unused, outdated or recalled Medication ~~are~~ logged on Discontinued Medication Log.	

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A36	Continued From Page 6 2009 was not initialed for a dose of Methadone on February 19, 2009 prescribed to Resident #2 scheduled for 6:00 PM and no MAR documentation as to why. On 06/23/09 during review of administrative records, it was noted that the MAR for February 2009 was not initialed for the following medications prescribed for Resident #4: no initials for AM dose of Lexapro on February 10, 2009 and no MAR documentation as to why, no initials for AM dose of Hydralazine on February 10, 2009 no MAR documentation as to why, no initials for PM dose of Hydralazine on February 25, 2009 with no MAR documentation as to why, no initials for 2 PM doses of Atenolol on February 12, 2009 and February 25 with no MAR documentation as to why, no initials for AM dose of Isosorbide Mononitrate on February 10, 2009 no MAR documentation as to why, no initials for AM dose of Clonidine on February 10, 2009 no MAR documentation as to why. B. On 7/22/09 during interview with the Owner, she acknowledged the documentation discrepancy and stated that she would appropriately address the issue.	A36	A. A Plan of Action was mandated by Auditing Pharmacy in February 2009. Staff has that Plan Action tape to Medicine Cabinet Door. ~~Owner~~ Staff will check documentation Weekly for errors. Step by Step instructions are on Medication Door. Staff will be retrained to read Policy + Procedure State + Federal Regulation on Medication Door. Staff will be instructed to fill all Legal Documents. B. Owner will address this with staff and reiterate the importance of any and all documentation to do with the residents and the Facility as a whole.	
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).	A66		

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A66	Continued From Page 7 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/or 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 1 direct care staff (Employee #1). The findings are: A. On 6/23/09 at 11:00 AM during review of employee records, it was noted that one (1) direct care staff did not have on file a CCHS screening on file subsequent to hire within the required timeframes or documentation of a full or partial Caregivers Criminal History Screening (CCHSP) clearance addressed to the facility conducted subsequent to hire within the required timeframes. B. On 7/22/09 at 2:00 PM during an interview with the Owner, she acknowledged the matter and stated that she would address the matter.	A66	A. Owner will instruct Staff on the Where abouts of any and all records for the Surveyor @ time of Servey. Retraining will be Conducted on 8/6/09. Mock Survey will done to follow. and documented. All Regulations will be updated. B. Staff will be instructed on proper filing practices Where to look for all documentation for Re-Sidents & Facility as a whole. 8/6/09. All amended Regulations are on file and staff will be retrained on 8/6/09 to all updates to regulation and where they are filed A. All staff records will be rechecked for any discrepancies, by owner to make sure all records are filed with appropriate agencies. B. Owner failed to file CCHS and those documents where sent on 7/28/09.	