Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4032	A. BUILDING: _____ B. WING _____	C 06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY AT SANTA FE	3 AVENIDA ALDEA SANTA FE, NM 87507

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A 000	Initial Comments The following deficiencies were cited as a result of a Full-Onsite/Complaint Survey completed on 06/20/18 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake # 30541 was substantiated with deficiencies cited. Complaint Intake # 30764 was substantiated with deficiencies cited.	A 000	DISCLAIMER: This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies,or (if applicable) the administrative sanctions imposed on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors.	
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC;	A 017	A 017 1) DCS #2 completed the required 16 hours of supervised training and the box was checked on the communities "Initial Orientation and Annual Continuing education form on 6-20-18. 2) DCS #3 completed the required 16 hours of supervised training and the box was checked on the communities "Initial Orientation and Annual Continuing education form on 6-20-18 3) DCS #7 the box was not checked on the Intial Orientation and Annual Continuing education form as the employee was terminated on 4-9-18, the employee did not complete the following trainings First Aid, Safe Food Handeling, Methods to Provide Quality Care training as the employee was terminated on 4-9-18.	6-20-18 6-20-18 4-9-18

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A 017	Continued From page 1 (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 A B C (2) (3) (9) (12) Based on record review and interview, the facility failed to ensure for 4 (DCS #s 2, 3, 7 and N #1) of 4 (DCS #s 2, 3, 7, and N #1) Direct Care Staff and nurse whose staff files were reviewed for training compliance received the following required training's at orientation: 1. 16-Hours of supervised training, prior to providing unsupervised care. 2. First Aid 3. Methods to Provide Quality Resident Care 4. The Proper Way to Implement an Individual Service Plan (ISP) This deficient practice has the potential for all residents to be at risk of harm, if they are being provided care by staff who have not received all the required orientation training's. The findings are:	A 017	A 017 Continued 4) N#1 the box was not checked for the supervised training on the Initial Orientation and Annual Continuing education form as the employee was terminated on 03/30/18 from the community. The following trainings were not completed as the employee was terminated on 03/30/18 from the community, First Aid training, methods to provide quality care, and the proper was to implement a ISP The Business Office Manager (BOM) and Health and Wellness Director (HWD) were re-inserviced by the Executive Director on 10-19-18 to ensure all new and existing employees complete all required training prior to assisting with resident care (16 hours of shadowing before starting plus 12 hours of training plus annual training along with new employee orientation) and that the box is checked correctly. Business Office Manager and Health and Wellness Director re-inserviced to ensure that all computerized required trainings are completed as indicated. The BOM completed a 100% audit on10-19-18 of the files to ensure compliance that all appropriate boxed are checked for the required 16 hours of shadowing before starting plus 12 hours of training plus annual training along with new employee orientation are completed as indicated. The audit revealed 100% compliance. Compliance will be monitored by the BOM and .or designee through the use of tracking form created for personnel files and is to be monitored weekly X1 month, then monthly thereafter. The tracking form will be utilized for all new employee hires, new volunteers new personal care attendants and /or employees who change positions to ensure appropriate state mandated items such as 16 hours of shadowing before starting plus 12 hours of training plus annual training along with new employee orientation, First aid, how to properly implement a ISP, safe food handeling, and other trainings required by the state. Continued compliance will be monitored by the ED thereafter quarterly spot audits and through the annual quality assurance process.	03/20/18 10/19/18 10/19/18

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A 017	Continued From page 2 Findings related to DCS #2 A. Record Review of the staff file for DCS #2 (date of hire 03/12/18), revealed the 16-hrs of supervised training, prior to providing unsupervised care, box was not checked as completed on the facility's "Initial Orientation and Annual Continuing Education" form. B. Record Review of the staff file for DCS #3 (date of hire 01/15/18), revealed the 16-hrs of supervised training, prior to providing unsupervised care, box was not checked as completed on the facility's "Initial Orientation and Annual Continuing Education" form. C. Record review of the staff file for DCS #7 (hire date 02/25/18), revealed: 1. The 16-hrs of supervised training, prior to providing unsupervised care, box was not checked as completed on the facility's "Initial Orientation and Annual Continuing Education" form. 2. No documentation of First Aid training. 3. No documentation of Safe Food Handling training. 4. No documentation of Methods to Provide Quality Care training. D. Record review of the staff file for N #1 (hire date 01/10/18) revealed, no documentation of the following training's: 1. The box for 16-hrs of supervised training, prior to providing unsupervised care was not checked as completed on the facility's "Initial Orientation and Annual Continuing Education" form. 2. No documentation of First Aid training. 3. No documentation of Methods to Provide Quality Care training.	A 017	A017 continued. Corrective actions will be completed on or before 10-30-18 A017 1)DCS #2 completed the required 16 hours of shadowing before starting plus 12 hours of training plus annual training along with new employee orientation and the box was checked on the communities "Initial Orientation and Annual Continuing education form on 6-20-18. 2) DCS #3 completed the required 16 hours of shadowing before starting plus 12 hours of training plus annual training along with new employee orientation and the box was checked on the communities "Initial Orientation and Annual Continuing education form on 6-20-18 3) DCS #7 the box was not checked on the Intial Orientation and Annual Continuing education form as the employee was terminated on 4-9-18, the employee did not complete the following trainings First Aid, Safe Food Handeling, Methods to Provide Quality Care training as the employee was terminated on 4-9-18. 4) N#1 the box was not checked for the 16 hours of shadowing before starting plus 12 hours of training plus annual training along with new employee orientation as the employee was terminated on 03/30/18. The following trainings were not completed as the employee was terminated on 03/30/18, first aid training methods to provide quality care, and the proper way to implement a ISP.	06/20/18 06/20/18 04/09/18 03/30/18

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A 017	Continued From page 3 4. No documentation of The proper way to implement an ISP training. E. On 06/18/18 at 12:04 pm, during an interview with the Business Office Manager (BOM), she confirmed that there was no documentation that DCS #s 2, 3, 7 and N #1 received 16-hours of supervised training, prior to providing unsupervised care. She also confirmed that there was no documentation that: 1. DCS #7 received orientation training in: a. No documentation of First Aid training. b. No documentation of Safe Food Handling training. c. No documentation of Methods to Provide Quality Care training. 2. N #1 received orientation training for: a. No documentation of First Aid training. b. No documentation of Methods to Provide Quality Care training. c. No documentation of The proper way to implement an ISP training. F. On 06/18/18 at 1:14 pm, during an interview with DCS #2, she stated that she shadowed DCS #6 for about 2 weeks before working alone. G. On 06/18/18 at 1:30 pm, during an interview with the BOM, the missing training's (reviewed computer training's) and 16-hours of shadowing were discussed, the BOM stated that the training could be getting done, but she reconfirmed that there was no documentation.	A 017	A017 continued The Business Office Manager (BOM) and Health and Wellness Director (HWD) were re-inserviced by the Executive Director on 10-19-18 to ensure all new and existing employees complete all required training prior to assisting with resident care 16 hours of shadowing before starting plus 12 hours of training plus annual training along with new employee orientation and that the box is checked correctly. Business Office Manager and Health and Wellness Director re- inserviced to ensure that all computerized required trainings are completed as indicated. Compliance will be monitored by the BOM and .or designee through the use of tracking form created for personnel files and is to be monitored weekly X1 month, then monthly thereafter. The tracking form will be utilized for all new employee hires, new volunteers new personal care attendants and /or employees who change positions to ensure appropriate state mandated items such as 16 hours of supervised training, First aid, how to properly implement a ISP, safe food handeling, and other trainings required by the state. Continued compliance will be monitored by the ED thereafter quarterly spot audits and through the annual quality assurance process. Corrective actions will be completed on or before 10-30-18	10/19/18 10-30-18
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a	A 020		

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A 020	Continued From page 4 designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved	A 020	A020 1) The Resident Lease Agreement contains addendum labeled Resident Handbook which includes staffing ratio as follows: The community employs sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents' needs. These are our minimum staffing requirements: Assisted Living & Memory Care During resident waking hours, the community will have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents. 2) During resident sleeping hours, fifteen (15) or fewer residents in the community will have at least one (1) direct care staff person on duty, awake and responsible for the care and supervision of the residents. 3) During resident sleeping hours, sixteen (16) to thirty (30) residents in the community will have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises. 4) During resident sleeping hours, thirty-one (31) to sixty (60) residents in the community will have at least two (2) direct care staff persons on duty and awake at all times and at least one (1) additional staff person immediately available on the premises. 5) During resident sleeping hours, more than sixty-one (61) residents in the community will have at least three (3) direct care staff persons on duty and awake at all times and one (1) additional staff person immediately available on the premises for each additional thirty (30) residents or fraction thereof in the community. In the memory care, the community will provide the sufficient number of trained staff member to meet the additional needs of the residents in a secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times.	

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A 020	Continued From page 5 sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical	A 020	A020 Continued 6) Staffing schedules are available upon request. 1) Information and evidence of specialized staff training when providing care to residents in a memory care unit are available at all times upon request. All staff complete Dementia care training via Relias. All training records are kept in a electronic format and are available upon request. The Business Office Manager (BOM) and Health and Wellness Director (HWD) were re-inserviced by the Executive Director on 10-19-18 to ensure all new and existing employees complete all required training in staff speciality training when providing specialized services (memory care) Business Office Manager and Health and Wellness Director re-inserviced to ensure that all computerized required trainings are completed as indicated. Compliance will be monitored by the BOM and .or designee through the use of tracking form created for personnel files and is to be monitored weekly X1 month, then monthly thereafter. The tracking form will be utilized for all new employee hires, new volunteers new personal care attendants and /or employees who change positions to ensure appropriate state mandated items such as information and evidence of staff speciality training when providing specialized (memory care) services, and other trainings required by the state. Continued compliance will be monitored by the ED thereafter quarterly spot audits and through the annual quality assurance process.	10/19/18

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A 020	Continued From page 6 condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES);	A 020		

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A 020	Continued From page 7 (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (8) (14) C (1) D (1) Based on record review and interview the facility failed to ensure for 3 (R #s 2-4) of 3 (R #s 2-4) residents whose Admission Agreements were reviewed for compliance that the agreements included the: 1. Staffing ratio 2. Information and evidence of staff speciality	A 020		

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A 020	Continued From page 8 training when providing specialized (memory care unit) services. This deficient practice has the potential for residents/families/legal representatives to not know: 1. How many staff are supposed to be on duty during each shift throughout the day. 2. What speciality training the staff who care for residents with dementia/memory loss in the Memory Care Unit should have. The findings are: A. Record review of the Admission Agreements for R #s 2-4, revealed that the agreements did not include the facility's staffing ratio or information and evidence of staff speciality training when providing specialized (memory care unit) services. B. On 06/19/18 at 12:34 pm, during an interview with the Community Relations Director, she confirmed that the Admission Agreements for R #s 2-4 did not include the facility's staffing ratio or information and evidence of staff speciality training when providing specialized (memory care unit) services. Based on record review and interview the facility failed to ensure that: 1. Team meetings were convened prior to admitting and or retaining residents receiving hospice services from an outside agency. 2. Individual Service Plans (ISPs) included coordination of care with the hospice agency. This deficient practice has the potential for residents receiving hospice services to not receive the higher level of care and services they	A 020	A020 continued 1) The HWD and ED are to ensure that team meetings are being convened prior to admitting and/ or retaining resident receiving hospice services from an outside agency as of 10-17-18. Health and Wellness Director re-inserviced by Regional Director of Health and Wellness, on 10-17-18, that prior to admitting or retaining a resident at the community who is in need of hospice services that a team meeting is conducted to include the following parties, resident, resident legal POA, and outside agency. At time of meeting a new ISP will be developed and signed by all parties. ISP will include outlined and specific services community will be providing and services hospice agency will be providing. Specific to home health aid visits, Nursing visits and coordination of medication orders and receipt of the medications. ISP for community will be completed, signed off by HWD, ED, Resident/POA, and reviewed with staff at each shift crossover in detail as to services to be provided. ISP will be entered in computer on the same day signatures were obtained. ED will review ISP's within 24 hours or next business day in the computer to ensure timeliness. ISP will be updated every 6 months or change of condition. All changes of condition, medications, and services will be formally discussed and signed off by HWD and Hospice Nurse. 2)Compliance will be monitored by the HWD and/or designee by a 100% audit of the Individual Service Plans of resident who receive services from an outside agency (hospice) to ensure that team meetings are being conducted prior to a resident being admitted or retained at the community to a outside agency (hospice). Audits will be done weekly X4 weeks, then 1 time monthly X3 months, then quarterly thereafter. Continued compliance will be monitored by the ED thereafter through quarterly spot audits and through annual quality assurance process.	10/17/18 10-30-18

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A 020	Continued From page 9 need if: 1. A team meeting is not convened to determine if the resident requires a higher level of care than the facility is able to provide. 2. If there is no coordination of care with the hospice agency, the Direct Care Staff (DCS) will not know what care/services they need to provide and what care/services the hospice agency will provide. The findings are: A. Record review of R #6's resident file revealed, no documentation that a team meeting was convened prior to her admission to hospice on 03/22/18. B. Record review of R #6's ISP (dated 03/10/18) revealed, no coordination of care with the hospice agency. C. On 06/18/18 at 2:23 pm, during an interview with the Regional Health and Wellness Director (RH) she confirmed that: 1. A team meeting was not convened prior to R #6 being admitted to hospice services on 03/22/18. 2. That R #6's ISP (dated 03/10/18) did not include coordination of care with the hospice agency.	A 020		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a	A 021		

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A 021	Continued From page 10 table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and	A 021		

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A 021	Continued From page 11 (q) required diet; (6) 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; (7) entries by direct care staff, appropriate health care professionals and 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 ISP; (8) entries that provide 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 documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are	A 021		

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A 021	Continued From page 12 deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.21 A Based on record review and interview the facility failed to ensure that the resident records were organized, accessible, and readily available for review. This deficient practice has the potential for all 41 (R #s 1-41) residents, identified on the resident census provided by the Community Relations Associate (CRA) on 06/12/18. If the records are not immediately available (staff onsite were unable to access records requested), unorganized, and did not include accurate information. The findings are:	A 021	A021 1) Current Resident Records are maintained on site and stored in a organized manner. HWD to ensure by 10-30-18 that all resident clinical charts are maintained on site and are in a organized manner. HWD and ED to relocate clinical charts to Medication Room located on the first floor to ensure accessibilty. See Policy Resident Records A11. RDHW re-inserviced ED and HWD regarding Cloud manager (electronic medical record) for resident records. All records will be uploaded to Cloud Manager by 12-31-18 where they will be kept in organized and permanent manner. 2) ED and/or designee to in service all staff by 10-30-18 on how to access clinical records in the electronic format. Until the process is complete with uploading to electronic format all resident clinical charts will be kept in paper format. Once completed resident records in paper format will be kept as required, anything going forward will be uploaded directly to the Cloud Manager once all clinical charts have been uploaded. 3) The BOM, ED and HWD were re- inserviced by RDHW on how to use the electronic medical record paperless system and the ability to give immediate access to a legally authorized entity while paper documents are printing on 10-30-18 3) Compliance will be monitored by the ED through weekly audits of requesting staff to demonstrate how to give immediate access to electronic medical records for an authorized entity and requesting several records to be printed simultaneously within 15 minutes. Any issues in immediate access will be immediately corrected. Continued compliance will be monitored by the ED through quarterly random demonstrations of requesting staff to demonstrate giving immediate access to electronic records for an authorized entity and requesting several records to be printed simultaneously within 15 minutes	12-31-18 10-30-18 10-30-18

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A 021	Continued From page 13 A. Record request for R #1's resident chart was made on 06/12/18 at 9:30 am and was not received until 06/12/18 at 1:08 pm. B. On 06/12/18 at 10:24 am, during an interview with the CRA, she stated that she is working on the resident list and she has contacted the Regional Health and Wellness Coordinator (RHWC) in Florida to see where the key is to get access to resident charts, because the staff onsite do not have access or knows were the key is. C. On 06/12/18 at 11:00 am, during an interview with Direct Care Staff (DCS) #1, she attempted to bring up R #1's Electronic Medication Administration Record (EMAR). She stated that according to the computer R #1 was admitted to the facility on 03/22/18. DCS #1 stated that R #1's (EMAR) has been pulled from the computer since she is no longer a resident. D. Record review of R #'s 4 and 5's resident charts revealed, they did not include evaluations Individual Service Plans (ISPs), service provided check lists, or medication check in logs. The staff onsite were not able to access the records in the computer, the Regional Health and Wellness Director (RHWD) had to print the documents in Florida and fax to facility. E. On 6/13/18 at 1:15 pm, during an interview with DCS #1, she stated that she does not have access to resident ISPs in the computer system, she has called the corporate office for assistance, because no one whose is here [in the facility] has access. F. On 06/14/18 at 11:15 am, during an interview with the CRA, she stated that she is not able to to	A 021	A021 continued 2) HWD in-serviced all staff to ensure staff are able to accurately access residents Electronic Medication Administration Record (EMAR) and how to access discharged residents records in system, by 10-30-18 HWD will monitor staff accessability through spot checks weekly X4 weeks then monthly thereafter. Staff will correctly demonstrate how to acccess EMAR records from current and discharged residents. 3) R#4 and 5 resident evaluations , service provided check lists are maintained in electronic format. HWD in-serviced all staff to ensure staff are able to accurately demonstrate how to obtain resident records that are maintained in electronic format, resident evaluations, and service check lists, by 10-30-18. HWD in-serviced by RDHW on 10-18-18 that upon admission of a resident a medication check in log is completed and placed in the resident clinical chart. RDHW sent to community all documents that were requested by state agency.	10-30-18 10-30-18 10-18-18

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A 021	Continued From page 14 access R #6's (deceased) March 2018 MAR from the computer. The only MAR she can access is blank. The CRA said that the staff that are currently at the facility are unable to access MARs/ISPs in the computer. She will try to access the evaluations and service check logs. G. On 06/14/18 at 1:05 pm, during an interview with the Community Relations Director (CRD), she stated that the RHWD will show staff how to access/print past resident's MARs, ISPs, and service check sheets. The CRD stated that the interim Administrator is on vacation and she was instructed to refer surveyor to the RHWD in Florida. The Business Office Manager (BOM) is also on vacation and the facility nurse is sick and cannot come into the building. H. On 06/14/18 at 2:17 pm, during an interview with the RHWD she was informed that the administrative staff currently at the facility are not comfortable confirming findings, not having administrative staff at the facility to assist with survey, making it difficult to access needed documents, reports, and delaying the process. RHWD confirmed that the Administrator and Business Office Manager (BOM) are on vacation (BOM will be back on 06/18/18) and that the facility nurse is out sick and not available. RHWD stated she will access needed documents and reports (ISPs, Evaluations, Progress notes) from her office in Florida and will assist staff at the facility with getting the additional records. I. On 06/20/18 at 2:05 pm, during an interview with the Interim Administrator, she confirmed that records were disorganized and the available staff at the facility (including herself) have limited access or do not know how to access resident records.	A 021	A021 continued 4) HWD and ED in-serviced by RDHW on 10-18-18 that all resident ISP's are to be printed and placed in a binder for all staff to review to ensure all care staff know what services to provide for the residents. 5) Compliance will be monitored by HWD and or designee weekly X4 then monthly there after to ensure that all ISP's are current and available for the staff to review to ensure all care staff know what services to provide for the residents. Continued complaince will be monitored by the ED through quarterly spot audit checks and through annual quality assurance process. RDHW provided all available and completed documents requested by the state agency . Corrective actions will be completed on or before 10-30-18	10/18/18 10-30-18

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A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to 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; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage.	A 026	A026 HWD and/or designee will implement an ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident's health status. The ISP shall include the following: •a description of identified needs as noted in the resident evaluation; •a written description of all services to be provided; •who will provide the services; •when or how often the services will be provided; •how the services will be provided; •where the services will be provided; •expected goals and outcomes of the services; •documentation of the facility's determination that it is able to meet the needs of the resident; •the level of assistance that the resident will require with activities of daily living and with medications; •a crisis prevention/intervention plan when indicated by diagnosis or behavior; and •current orders for all medications, including those authorized for PRN usage. Compliance will be monitored by the HWD and/or designee monthly to ensure all ISP are updated. Crisis interventions will be updated on a as needed basis determined by the behavior. Resident and resident POA will be involved with intervention process. Continued complaince will be monitored by the ED through quarterly spot audit checks and through annual quality assurance process.	

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A 026	Continued From page 16 [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (1) 3) (10) Based on record review and interview the facility failed to ensure that Individual Service Plans (ISPs): 1. Addressed behaviors and included a crisis prevention/intervention plan. 2. Were updated when a change in condition occurred. 3. Included coordination of care with the Hospice agency. These deficient practices have the potential for all 41 (R #s 1-41) residents listed on the resident census provided by the Community Relations Associate (CRA) on 06/12/18 to be at risk of harm, abuse, and not receiving the care/services needed if: 1. The Direct Care Staff (DCS) do not know what actions to take if a resident is being abusive or inappropriate, because there is no crisis prevention/intervention plan included in the resident's ISP. 2. The DCS are not aware of the higher level of care is needed when a change in condition occurs. 3. A resident needs a higher level of care than the facility can provide is admitted of retained at the facility. 4. The ISP does not include coordination of care between the facility and hospice agency so the DCS will know what care/services they are to provide and what the hospice agency will provide.	A 026	A026 Continued 2) HWD will re-inservice all staff by 10-30-18 related to residents needing a higher level of care or when care is needed to change due to a change in the residents condition, DCS to review ISP once the change is noted and updated by HWD and/or designee. Compliance will be monitored by the HWD and/or designee monthly to ensure all ISP are updated. Crisis interventions will be updated on a as needed basis determined by the behavior. Resident and resident POA will be involved with intervention process. Continued complaince will be monitored by the ED upon admission of residents then quarterly spot audit checks and through annual quality assurance process, to ensure ISP are completed and updated on any change of condition. Corrective actions to be completed on or before 10-30-18	10-30-18 10-30-18

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A 026	Continued From page 17 The findings are: Findings related to R #2 A. Record review of R #2's ISP (reviewed on 03/23/18) revealed, the ISP was not updated after he began having verbal and physical aggressive behaviors with other residents on 04/06/18 and no crisis prevention/intervention plan was developed. B. On 06/19/18 at 12:34 pm, during interview with the Health and Wellness Director (HWD) she confirmed that R #2's ISP was not updated after he began having verbal and physical aggressive behaviors on 04/06/18 and there was no crisis prevention plan developed. Findings related to R #3 C. Record review of R #3's ISP (dated 03/09/18) for Mental Status, Behaviors, and Redirection revealed, it had not been updated to reflect the resident to resident verbal/physical abuse beginning on 04/25/18 and no crisis prevention/intervention plan developed. D. On 06/19/18 at 12:34 with the Community Relations Director (CRD), Community Relations Associate (CRA), and HWD, they confirmed that R #3's ISP had not been updated to reflect the resident to resident verbal/physical abuse beginning on 04/25/18 and did not include a crisis prevention/intervention plan. Findings for R #6 E. Record review of R #6's ISP dated (03/10/18), revealed, it was not updated when a change in condition occurred, admitted to hospice services	A 026		

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A 026	Continued From page 18 on 03/22/18, and there was no documentation of coordination of care with the hospice agency. F. On 06/18/18 at 2:23 pm, during interview with the Regional Health and Wellness Director (RHWD) she confirmed that R #6's ISP (dated 03/10/18), was not updated when she had a change of condition, admitted to hospice services on on 03/22/18, and there was no documentation of coordination of care with the hospice agency.	A 026	A032 1)Prior to working unsupervised with residents, the community shall provide all employees and volunteers with a written training curriculum and shall train them on incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents. Refresher training shall be provided at annual, not to exceed twelve (12) month, intervals. The training curriculum may include computer-based training. Reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the licensed health care facility. Training shall be conducted in a language that is understood by the employee and volunteers The community will post at least three (3) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and internet addresses. The posters shall also be posted where employees report each day and from which the employees operate to carry out their activities. The community will take steps to ensure that the notices are not altered, defaced, removed, or covered by other material. Community Staff will immediately (within 24 hours) report a resident's condition that might indicate the above incidents to the Executive Director (ED) or designee. However, any person may report an incident to the bureau by utilizing the DHI toll free complaint hotline at 1-800-752-8649. The staff member with direct knowledge of the incident must immediately fill out an Incident Report Form and turn in to the ED or designee. . Continued compliance will be monitored will be monitored by the ED quarterly and through the annual quality assurance process	
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report	A 032		

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A 032	Continued From page 19 form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A B Refer to 7.1.13.7 W. & 8 B. (2) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the	A 032	A032 Continued The ED will complete the online IM Report to DHI within 24 hours of notification of the incident or the next business day when the incident occurs on a weekend or holiday utilizing the incident report form. The website for submission is http://dhi.state.nm.us/imb/imb_irform.php. For electronic submission, to ensure proper receipt of the Incident report, fax a copy of the printed online form with tracking number to 888-572-0012 in addition to submitting it online. If the incident involves ANE. The resident is evaluated by the ED or designee for physical injury and/or any psychological harm that may have occurred as a result of the incident. The community will not delay a report to the complaint hotline while an internal investigation is occurring. Documentation will be kept confidential by the community to the extent required by state law. Copies of reports filed with the state or local law enforcement will be tracked and kept by the community. If the investigation validates the claim, the employee will be terminated and the incident(s) reported to appropriate state department, state licensing board, or law enforcement official. In instances of resident to resident abuse, the aggressive resident may be asked to be immediately moved from the community. The community will submit a written report, "Health Facility Complaint Investigation Five Day Follow-up Report form" to DHI Complaints Units within five (5) days from the date or discovery of the incident. containing the following: 1. a brief narrative description of the incident; 2. the conclusion of the incidents 3. corrective actions and plans to prevent further incidents. HWD and RSC will take part in shift crossover, read documentation in communication book and resident chart to monitor and ensure that any incidents are being documented and investigated immediately. Continued compliance will be monitored by the ED and/or designee through the quarterly assurance process	10-30-18

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bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form

Based on record review and interview the facility failed to ensure that:

1. Incidents of suspected abuse, neglect, or unusual occurrence were reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday.

2. A facility internal investigation was conducted and a follow-up report was submitted to the Licensing Authority within 5 business days of the incident.

This deficient practice has the potential for the 41 (R #s 1-41) residents listed on the resident census, provided by the Community Relations Associate (CRA) on 06/12/18, to be at risk of harm, injury, and/or death, if there is no oversite by the Licensing Authority because the facility failed to:

1. Report incidents or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority within 24 hours or the next business day if a weekend or holiday.

2. Submit a follow-up investigation report within 5-business days after the incident. The findings are:

Findings for R #1

A. Record review of Licensing Authority complaint intake revealed, the facility did not

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submit an internal investigation report to the Licensing Authority within 5 business days after R #1 was found on the floor on 03/26/18 (unwitnessed fall) in the hallway with her nose bleeding, an abrasion on her forehead, and required transport/treatment in the Emergency Room.

B. On 06/13/18 at 12:55 pm, during an interview with the Community Relations Director (CRD), she confirmed based on the records reviewed that no-5-day follow-up internal investigation report was sent to the Licensing Authority for R #1's unwitnessed fall with injury on 03/26/18.

Findings for R #s 2 & 3

C. On 06/13/18 at 11:20 am, during an interview with [name of Ombudsman (resident advocate)], she reported that on [redacted]18, R #2 hit R #3 in the face and the incident of resident to resident abuse was not reported to the state.

D. Record review of R #2's progress notes revealed:

1. On [redacted]18 at 9:14 pm, R #2 was highly agitated and had an altercation with another resident (resident-resident abuse) that became physical.

2. On [redacted]18 at 10:24 pm, R #2 was in an altercation (verbally/possibly physical) with R #3. R #2 was attempting to enter R #3's room, R #3 began shouting for R #2 to leave. R #2 was holding the door handle, while banging on the door. Direct Care Staff (DCS) #5 was able to redirect R #2 back to [redacted]room. DCS #5 noted that she did not see R #2 hitting or raising [redacted] hands to R #3. The police were called at R #3's request.

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A 032	Continued From page 22 E. Record review of R #3's progress notes revealed: 1. On [redacted]/18 at 10:17 pm, R #3 was involved in an altercation with R #2. DCS #5 heard a lot of banging and some yelling. DCS #5 saw R #2 standing in R #3's doorway and R #3 was shouting at R #2 to leave [redacted] room. DCS #5 was able to redirect R #2 back to [redacted] room. When DCS #5 went back to check on R #3, [redacted] was shaken and stated that R #2 had hit [redacted] DCS did not see any sign of injury from the altercation. The police were called at R #3's request. 2. On [redacted]/18 at 3:48 pm, R #3 was observed by DCS #5, provoking and poking R #2 in the shoulder numerous times asking R # 2 how [redacted] liked being hit. R #3 was asked to return to [redacted] room and [redacted] did. 3. On 05/12/18 at 10:24 pm, R #3 was involved in an altercation with another resident (name unknown) that struck [redacted] in the neck and throat. F. Record review of R #s 2 & 3's resident files revealed, no documentation that the resident to resident abuse incidents were reported to the Licensing Authority. G. On 06/19/18 at 12:34 pm, during an interview with Community Relations Director (CRD), Community Relations Associate (CRA), and the Health and Wellness Director (HWD), they confirmed that the facility did not report the incidents of resident to resident abuse for R #s 2 & 3 to the Licensing Authority. Findings for R #6 H. Record review of R #6's resident file revealed, a completed incident report (state form) for an	A 032		

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A 032	Continued From page 23 unwitnessed fall on 03/20/18 where R #6 broke her wrist. There was no documentation that the report was sent to Licensing Authority. I. On 06/14/18 at 1:12 pm, during an interview with the Complaint Supervisor/Licensing Authority, she confirmed that no report was received for R #6's unwitnessed fall with injury (broken wrist) on 03/20/18. J. Record review of the facility's internal incident report (dated 04/29/18) for R #6 for an unwitnessed fall where she died soon after (unusual occurrence) revealed, no documentation that the incident was reported to the Licensing Authority. K. On 06/19/18 at 9:00 am, during an interview with the Community Relations Director (CRD), she confirmed that there was no documentation that the incident report completed for R #6's fall (broken wrist) was sent to the Licensing Authority. L. On 06/20/18 at 1:34 pm, during an interview with the Regional Health and Wellness Director, she confirmed that there was no incident report for R #6's unwitnessed fall on 04/29/18 (died after fall) sent to the Licensing Authority.	A 032		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding.	A 033		

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A 033	Continued From page 24 B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record;	A 033		

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A 033	Continued From page 25 (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development	A 033		

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A 033	Continued From page 26 of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Surveyor: Curlee, Alana 7.8.2.33 D (4) (11) (a) 7.8.2.7 DEFINITIONS: "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish and is defined in the Incident	A 033		

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A 033	Continued From page 27 Reporting Intake, Processing & Training Requirements, 7.1.13 NMAC. . . . AW. "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness and is defined in the Incident Reporting Intake, Processing & Training Requirements, 7.1.13 NMAC. 7.1.137. DEFINITIONS: . . . T. "Neglect" means the failure of the caretaker to provide basic needs of a person, such as clothing, food, shelter, supervision and care for the physical and mental health of that person. Neglect causes, or is likely to cause, harm to a person. Based on record review and interview the facility failed to ensure that 4 (R #s 1-3 and 6) of 4 (R #s 1-3 and 6) residents were free of abuse (physical/verbal) and neglect because: 1. The Direct Care Staff (DCS) were not able to provide the care/services/medications immediately upon admission to the facility. 2. Emergency medical services were delayed. 3. Individual Service Plans (ISPs) were not updated to address aggressive/abusive behaviors and included a crisis prevention/intervention plan. 4. The DCS did not conduct 1 hr safety checks for residents as requested and implemented. 5. Physician (hospice) ordered medications were not received or administered. 6. No administrative/nursing staff were available to be onsite to assist/support the DCS during a crisis situation.	A 033	A033 The Providers Plan of Care Medication Section will be completed up to thirty (30) days prior to move-in or on the day of move-in. If the resident is coming from a skilled facility, hospital, or another community, the provider must have approved, signed, and dated a current medication list or provide individual prescriptions for each medication/treatment for the resident. Medications and treatments include over-the-counter medications/treatments and prescriptions, i.e. oxygen, vitamins, topical medication creams, etc. Prescription bottles are NOT a signed order from a provider.Upon move-in, the resident and/or family member will bring their medications in their original bottles. The following will be adhered by and is not an all-inclusive list: a. Prescription drugs must be in their original containers. b. All prescription medications must be dispensed through a pharmacy or by the resident's treating provider or dentist c. No pill reminders will be accepted. d. Pills that are mixed with others will not be accepted. e. Medications/treatments without current orders will not be taken from the resident or family until current provider orders are given to the community. f. Lotions and creams without medications impregnated in them are acceptable without orders and can be kept at the resident bedside if cognitively able or applicable.	

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A 033	Continued From page 28 This deficient practice has the potential for residents to be at risk of harm, injury, or death if: 1. The DCS are not able to provide the care/services and medications needed. 2. Needed emergency medical service are not received timely. 3. The DCS do not know how what interventions are to be used when residents with aggressive abusive behaviors. 4. The DCS do not conduct 1 hr checks on residents whose safety is at risk. 5. Physician ordered medications are not received or administered. 6. There is no administrative/ensuring staff immediately available to be onsite to assist/support DCS during a crisis situation. The findings are: Findings for R #1 A. Record review of R #1's Admission Resident Medication Profile (dated 03/24/18) revealed, that Nurse (N) #1 checked-in R #1's medications into the facility B. Record review of R #1's March 2018 MAR (Medication Administration Record) revealed, no documentation of R #1 being assisted with her medications by the DCS from 03/24/18 (date of admission) until 03/27/18. C. On 06/12/18 at 1:25 pm, during an interview with the Interim Administrator, she confirmed that R #1's medications were received by N #1 on 03/24/18. She also confirmed that R #1's March 2018 MAR (medication administration record) revealed, she did not receive any medications from facility staff until 03/27/18.	A 033	A033 continued The HWD or designee will contact the resident's primary provider if there are any discrepancies in the signed orders and bottles. The Medication Associate or HWD will order medications if needed from the resident's preferred pharmacy. All medications will be logged and counted with two people present with the following information on an Admission Resident Medication Profile: a. Name of prescribed medication/treatment b. Strength c. Dosage d. Amount Received e. Directions for use f. Route of administration Prescription number (if any) h. Pharmacy name (if any) i. The date each medication was issued from the pharmacy (if any) 7. The current orders are faxed to the community contracted pharmacy for entry into the electronic Medication Administration Record (MAR) or the HWD or designee may manually enter the medications/treatments into the electronic MAR. 8. Medications will be stored in a locked cabinet separate from other resident's medications. Narcotics will be double locked and an individual narcotic sheet will be started for the resident. 9. The Admission Resident Medication Profile is filed in the electronic resident record under Admission. 10. HWD and ED are available 24/7 and can be on the property at Community within 30 minutes in case of any emergency, crisis or situation that cannot be taken care of by med tech. Lead Caregivers have been put in place for each shift, they are responsible for ensuring all services are met, meds are given on time. 2) ED to re- inservice all staff to ensure that when emergency services are needed they are notified immediately to ensure no delay. staff will then notifiy ED and/or designee of resident needing emergency services by 10-30-18	10-30-18

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A 033	Continued From page 29 D. On 06/13/18 at 1:33 pm, during an interview with DCS #3, he stated that he gave R #1's daughter back the medications on 03/25/18, because R #1 was not yet in the computer system and there were no physician's order for the medications, therefore the DCS could not assist R #1 with her medications. E. On 06/19/18 at 9:45 am, during an interview with DCS #1, she confirmed that R #1's daughter actually gave the morning medications on 03/26/18. DCS #1 stated she just initialed that R #1 received the medication. F. Record review of R #1's ISP-(dated 03/27/18) revealed, it was not completed/entered into the computer system upon admission (03/24/18), therefore the DCS did not know what care/services to provide the resident until after her fall with injury on 03/26/18. G. On 06/12/18 at 1:45 pm, during an interview with the Interim Administrator, she stated that the facility's computer system requires that ISP's need to be completed on the day of admission so the resident's care and services need immediately available to the DCS. She confirmed that the ISP for R #1 (admission date 03/24/18): 1. Was not completed until 03/27/18, 2. Was not entered into the computer until 03/27/18, 3. That the DCS did not know what care/services to provide. H. Record review of a complaint intake revealed, R #1's unwitnessed fall (03/26/18) in the hallway with her nose bleeding, an abrasion on her forehead which required transport to the emergency room for treatment. The report stated that the incident occurred at 9:15 am and the	A 033	A033 continued 3) HWD and/or designee will implement an ISP shall be developed and implemented within ten (10) calendar days of admission and no later than the day of admission for each resident residing in the facility. The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident's health status. The ISP shall include the following: •a description of identified needs as noted in the resident evaluation; •a written description of all services to be provided; •who will provide the services; •when or how often the services will be provided; •how the services will be provided; •where the services will be provided; •expected goals and outcomes of the services; •documentation of the facility's determination that it is able to meet the needs of the resident; •the level of assistance that the resident will require with activities of daily living and with medications; •a crisis prevention/intervention plan when indicated by diagnosis or behavior; and •current orders for all medications, including those authorized for PRN usage. The ISP shall be entered in the computer by the time of admission. Staff shall be made aware that there is a new admission by posting documentation in the communication book, reviewed at shift crossover for every shift and signed off by all staff until every staff member has been accounted for before caring for the new resident. 4) Community does not provide 1 hour checks, Community does provide frequent checks for all residents. In circumstances that there is an agreement made with resident or family that there will be more frequent checks due to safety or change in condition, this will documented in	

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A 033	Continued From page 30 EMTs (emergency medical technicians) were not notified until 10:10 am. I. On 06/13/18 at 1:45 pm, during an interview with the Community Relations Director (CRD), she confirmed that the incident report says that the fall occurred at 9:15 am and the EMTs were not called until 10:10 am. J. On 06/21/18 at 11:40 am, during an interview with N #1, she confirmed that she did a full admission for R #1 on Saturday (03/24/18). She checked in medications, did assessment, and skin check. The DCS were to start assisting R #1 with her medications on Sunday (03/24/18). N #1 stated that she entered R #1 into the computer system but cannot remember if she did it on Saturday, March (03/23/18) or prior to her admission. N #1 stated that R #1 was in the system when she gave report to the evening shift DCS on Saturday. On Monday (03/25/18) morning she was told by the DCS that R #1's medications were not in the system. When N #1 checked the system it kept saying R #1 had not been admitted. N #1 stated that R #1 was in the system on Saturday, but not on Monday, she does not know why. N #1 said that on Monday 03/26/18, she received a call that R #1 had fallen. N #1 did an assessment, R #1 was bleeding from her nose and had a scratch on her forehead. N #1 then called the resident's daughter and the EMTs she completed an incident report. She was not there to see what the DCS saw on Sunday. As a nurse she did everything she should have done for the admission. She assessed the resident before she moved into her room. Findings for R #s 2 & 3 K. On 06/13/18 at 11:20 am, during an interview	A 033	A033 continued In the communication book and at shift crossover and signed off by all staff. HWD will communicate with resident and family to ensure they are receiving care they were expecting. Continued compliance will be monitored by the Ed and/or designee weekly X4 then monthly and through the quality assurance process to ensure all staff are able to assist with medications upon admission. HWD and/or designee to ensure that all physician orders are obtained in a timely manner. If clarification orders are needed and there is no response from PCP HWD and/or designee will go to PCP office to obtain orders that are in need of clarification. Corrective Actions o be completed on or before 10-30-18.	10-30-18

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A 033	Continued From page 31 with [name of Ombudsman (resident advocate)], she reported an incident of resident to resident abuse on [redacted]18 where R #2 hit R #3 in the face. L. Record review of R #2's progress notes revealed: 1. On [redacted]18 at 9:14 pm, R #2 was highly agitated and had an altercation with another resident [name unknown] that became physical. 2. On [redacted]18 at 10:24 pm, R #2 was in an altercation (verbally/possibly physical) with R #3. R #2 was attempting to enter R #3's room, R #3 began shouting for R #2 to leave. R #2 was holding the door handle, while banging on the door. DCS #5 was able to redirect R #2 back to [redacted]room. DCS #5 noted that she did not see R #2 hitting or raising [redacted]hands to R #3. The police were called at R #3's request. M. On 06/19/18 at 9:47 am, an interview with R #2 was attempted, however he was not cognitively able to be interviewed. N. Record review of R #2's ISP (date of review of 03/23/18, no signature or date) for Mental Status, Behaviors, and Redirection revealed, the ISP was not updated after the incidents of resident to resident verbal/physically abuse and increased aggressive behaviors with other residents beginning on 04/06/18 and no crisis prevention/intervention plan was developed. O. On 06/19/18 at 12:34 pm, during an interview with the Health and Wellness Director (HWD), she confirmed that R #2's ISP was not updated to reflect the resident to resident (the verbal/physical) abuse and aggressive behaviors beginning on 04/06/18 and did not included a	A 033		

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A 033	Continued From page 32 crisis prevention/intervention plan. P. Record review of R #3's progress notes revealed: 1. On [redacted]/18 at 10:17 pm, R #3 was involved in an altercation with R #2. DCS #5 heard a lot of banging and some yelling. DCS #5 saw R #2 standing in R #3's doorway and R #3 was shouting at R #2 to leave [redacted] room. DCS #5 was able to redirect R #2 back to [redacted] room. When DCS #5 went back to check on R #3, [redacted] was shaken and stated that R #2 had hi[redacted] DCS #5 did not see any sign of injury from the altercation. The police were called at R #3's request. 2. On [redacted]/18 at 3:48 pm, R #3 was observed by DCS #5, provoking and poking R #2 in the shoulder numerous times asking R #2 how he liked being hit. R #3 was asked to return to [redacted] room and [redacted] did. 3. On 05/12/18 at 10:24 pm, R #3 was involved in an altercation with another resident (name unknown) that struck [redacted] in the neck and throat. Q. On 06/18/18 at 1:00 pm, during an interview with R #3 revealed, [redacted] did not respond appropriately when asked questions regarding the incidents with R #2. During the conversation R #3 was very fixated and told several different stories about men being improper with women in [redacted] adult life. In these stories [redacted] referred several of the female characters who were abused to call 911, when police arrived they were very handsome (this may be a reference to the recent resident to resident incident with R #2 where [redacted] insisted DCS call 911 and police responded). R #3 could not give any dates/times for [redacted] stories.	A 033		

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A 033	Continued From page 33 R. Record review of R #3's ISP (dated 03/09/18) for Mental Status, Behaviors, and Redirection revealed, it had not been updated to reflect the resident to resident verbal/physical abuse beginning on [redacted]18 and no crisis prevention/intervention plan developed. S. On 06/19/18 at 12:34 pm, with the CRD, Community Relations Associate (CRA), and HWD, they confirmed that R #3's ISP had not been updated. It was not updated to reflect the resident to resident verbal/physical abuse beginning on [redacted]18 and did not include a crisis prevention/intervention plan. Findings for R #6 Findings related to 1 hr checks T. Record review of a complaint intake NM#30764 (dated 06/14/18 revealed, that after R #6's fall w/injury (broken wrist) on 03/20/18 a request for 1 hr safety checks was made and the request was repeated during the week before resident's death. The complainant stated that the private duty aide found R #6 on the floor at 8:15 am on 04/29/18. The resident's daughter was informed that R #6 was last checked on at 5:45 am. on 04/29/18. Resident died at 8:36 am, on 04/29/18. U. Record review of R #6's resident file revealed, a completed incident report (state form) was found in her chart for an unwitnessed fall on 03/30/18 where R #6 broke her wrist. The prevention plan included more frequent checks by DCS. V. On 06/19/18 at 9:00 am, during an interview	A 033		

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with the CRD, she confirmed the DCS were supposed to be doing 1 hr checks on R #6, after the incident on 03/30/18 when she broke her wrist.

W. On 06/19/18 at 11:03 am, during an interview with DCS #11, he said he was not working in MCU (Memory Care Unit) at the time of R#6's death and was not aware that the DCS were supposed to be doing 1 hr checks on her.

X. On 06/19/18 at 11:05 am, during an interview with DCS #2, she said she was not working in MCU at the time of R #6's death and was not aware that the DCS were supposed to be doing 1 hr checks on her.

Y. On 06/20/18 at 2:15 pm, during an interview with the Interim Administrator, she confirmed that the DCS should have been conducting safety checks on R #6 every hour when her private duty caregiver was not there.

Z. On 06/21/18 at 11:21 am, during an interview with DCS #3, he stated that he was informed that R #6 was last checked on between 5:30 am and 5:45 am, on 04/29/18 and stated the resident was screaming in pain. DCS #3 stated that he was aware that R #6 was on 1 hr checks. The private duty caregiver found R #6 on the floor at 8:15 am at 04/29/18, it was unknown how long she was on the floor.

Findings related to medications

AA. Record review of a complaint intake NM#30764 revealed, that on Saturday (04/28/18) the day before R #6 death, an order for Haldol/Haloperidol (anti-Psychotic) 2 mg (milligrams), 1-2 tablets at bedtime to manage

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increased agitation at night was written by the hospice nurse.

BB. Record review of R #6's hospice nurse note (dated 04/28/18) revealed, an order for Haldol/Haloperidol (anti-Psychotic) 2 mg (milligrams), 1-2 tablets at bedtime to manage increased agitation at night was ordered.

CC. Record review of R #6's progress notes dated 04/28/18 revealed, that a new order for Haldol/Haloperidol (anti-Psychotic) was received by the facility HWD, but needed clarification.

DD. On 06/19/18 at 10:00 am, during an interview with the HWD, she confirmed R #6 did not receive the Haldol ordered by the [name of] hospice nurse on Saturday (04/28/18) the day before she died, because the prescription was written wrong and HWD was unable to reach the hospice nurse.

EE. On 06/19/18 at 10:05 am, during a phone interview with DCS #8, she stated that R #6 was still alive when she arrived to help assess her after having an unwitnessed fall in her room on 04/29/18 (exact time unknown). According to DCS #8, R #6's breathing was labored, she seemed agitated, and in pain. DCS #8 stated that the hospice nurse had been called on 04/27/18 and 04/28/18 regarding R #6's increased agitation and pain.

FF. On 06/23/18 at 2:30 pm, during interview with DCS #3, he stated that hospice was supposed to get R #6 liquid morphine for pain, the facility only had pills which was were not appropriate for R #6.

GG. Record review of R #6's April 2018 MAR

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revealed, an order for Morphine Sulfate/ML (pain/breathing) in liquid form, but is not signed that she ever received the medication.

Findings related to administrative staff not available

HH. Record review of [name of hospice RN] notes revealed,

1. 04/28/18 at 11:32 am; "Per med tech (DCS who assist with the self-administration of medications) texted the Regional Health and Wellness Director (RHWD) from facility. No Response". "Weekend supervisor not present for discussion of R #6"

2. 04/28/18 at 1:50 pm "Nurse (RHWD) does not answer phone to staff."

3. 05/02/18-Narrative: Hospice on call nurse [name of] was notified at 8:44 am on 04/29/18 that R #6 had passed away. At 11:01 am, hospice RN pronounced death of R #6. "Per facility Med Tech, they made multiple attempts to call facility nurse to no avail."

II. On 06/20/18 at 1:34 pm, during an interview with the HWD, she stated that a new HWD was hired, but did not start until 05/01/18 after R #6's death. The HWD stated that she was not at the facility when R #6 died. She said she she remembers talking to Hospice but does not remember if it was about R #6 or another resident. The HWD said she does not remember any conversations with DCS regarding R #6.

JJ. On 06/20/18 at 2:15 pm, during an interview with the Interim Administrator, she stated that her start date was on 04/24/18 and her first day at the facility was not until 04/30/18 (the day after R #6 died).

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A 033	Continued From page 37 LL On 06/20/18 at 2:30 pm, during an interview with DCS #5, he stated that after R #6's death he texted the new Interim Administrator who did not respond and the HWD (in Florida) did not respond to texts or phone calls. He said that when the former Administrator left, there was no Administrator, no Wellness Director, and the HWD only came to the facility 1 or 2 times and mostly communicated by phone. MM. On 06/25/18 at 4:55 pm, during an interview with DCS #5, she reported that on Saturday (04/28/18) the day before R #6 died she was in a lot of pain. DCS #5 stated there was no facility nurse available and when she called the HWD, she did not respond.	A 033		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. 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 from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in	A 035		

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accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing.
C. PRN (pro re nada) medication.
(1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified.
(2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP.
D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments.
E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur.
F. Medications prescribed for one resident shall not be used for another resident.
G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with

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A 035	Continued From page 39 self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error.	A 035		

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A 035	Continued From page 40 H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]	A 035		

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A 035	Continued From page 41 This REQUIREMENT is not met as evidenced by: 7.8.2.35 H Based on record review and interview the facility failed to ensure for 2 (R #s 1 & 6) of 2 (R #s 1 & 6)) residents whose records were reviewed for medication administration had the following: 1. Residents and their medications entered into the computer system and had physician orders for the medications that would allow the Direct Care Staff (DCS) to assist them with their medications. 2. Residents receiving physician (hospice) ordered medications. This deficient practice has the potential for residents to: 1. Not receive assistance with their medications from the DCS. 2. To suffer pain and anxiety at end of life, if physician (hospice) ordered medications are not received. The findings are: Findings for R #1 A. Record review of a complaint intake, revealed that on Monday 03/26/18 that R #1's daughter had to give the morning medications. B. Record review of R #1's Admission Resident Medication Profile (dated 03/24/18) revealed, that the Nurse (N) #1 checked-in R #1's medications into the facility C. Record review of R #1's March 2018 MAR (Medication Administration Record)revealed, no	A 035	A035 HWD and.or designee will ensure upon admission the following: 1)The Providers Plan of Care Medication Section will be completed up to six (6) months prior to move-in. Medications and treatments include over-the-counter medications/treatments and prescriptions, i.e. oxygen, vitamins, topical medication creams, etc. Prescription bottles are NOT a signed order from a provider. Upon move-in, the resident and/or family member will bring their medications in their original bottles. The following will be adhered by and is not an all-inclusive list: a. Prescription drugs must be in their original containers. b. All prescription medications must be dispensed through a pharmacy or by the resident's treating provider or dentist c No pill reminders will be accepted. d.Pills that are mixed with others will not be accepted. e. Medications/treatments without current orders will not be taken from the resident or family until current provider orders are given to the community. f. Lotions and creams without medications impregnated in them are acceptable without orders and can be kept at the resident bedside if cognitively able or applicable. The HWD or designee will contact the resident's primary provider if there are any discrepancies in the signed orders and bottles. The Medication Associate or HWD will order medications if needed from the resident's preferred pharmacy. All medications will be logged and counted with the following information on an Admission Resident Medication Profile: a. Name of prescribed medication/treatment b. Strength c. Dosage d. Amount Received e. Directions for use f. Route of administration g. Prescription number (if any) h. Pharmacy name (if any) i. Date Issued by the Pharmacy (if any)	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY AT SANTA FE	3 AVENIDA ALDEA SANTA FE, NM 87507

(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
A 035	Continued From page 42 documentation of R #1 being assisted with her medications by the DCS from 03/24/18 (date of admission) until 03/27/18. D. On 06/12/18 at 1:25 pm, during an interview with the Interim Administrator, she confirmed that R #1's medications were received by N #1 on 03/24/18. She also confirmed that according to R #1's March 2018 MAR, she did not receive any medications from facility staff until 03/27/18. E. On 06/13/18 at 1:33 pm, during an interview with DCS #3, he stated that he gave R #1's daughter back the medications on 03/25/18, because R #1 was not yet in the computer system and there were no physician's order for the medications. F. On 06/19/18 at 9:45 am, during an interview with DCS #1, she confirmed that R #1's daughter actually gave the morning medications on 03/26/18. DCS #1 stated she just initialed that R #1 received the medication. Findings for R #6 G. Record review of a complaint intake NM#30764 revealed, that on the day Saturday (04/28/18) before her death an order for Haldol/Haloperidol (anti-Psychotic) 2 mg (milligrams), 1-2 tablets at bedtime to manage increased agitation at night was written by the hospice nurse. H. Record review of R #6's hospice nurse note (dated 04/28/18) revealed, Haldol/Haloperidol (anti-Psychotic) 2 mg (milligrams), 1-2 tablets at bedtime to manage increased agitation at night. I. Record review of R #6's progress notes dated	A 035	A035 continued All medication detailed information will be entered in the computer (MAR) by the HWD that will follow the orders on each medication and gone over with the Medication Tech at time of admission. In the case that the admission happens on a weekend or when the HWD is not on the property, Medication Tech shall contact HWD, or Regional HWD, and ED to ensure that all medication is entered into the computer with specific instructions from the orders received within 2 hours of admission. ED and/or HWD are available 24/7. The current orders are faxed to the community contracted pharmacy for entry into the electronic Medication Administration Record (MAR) or the HWD or designee may manually enter the medications/ treatments into the electronic MAR. Medications will be stored in a locked cabinet separate from other resident's medications. Narcotics will be double locked and an individual narcotic sheet will be started for the resident. The Admission Resident Medication Profile is filed in the electronic resident and or physical chart record under Admission. 2) HWD and/or designee to ensure that all physician orders are obtained in a timely manner. If clarification orders are needed and there is no response from PCP HWD and/or designee will go to PCP office to obtain orders that are in need of clarification. HWD and/or designee will notify resident and POA regarding order clarification needed. Continued compliance will be monitored by the Ed and/or designee weekly X4 then monthly and through the quality assurance process to ensure all staff are able to assist with medications upon admission. HWD and/or designee to ensure that all physician orders are obtained in a timely manner. If clarification orders are needed and there is no response from PCP HWD and/or designee will go to PCP office to obtain orders that are in need of clarification. Corrective Actions will completed on or before	10-30-18

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A 035	Continued From page 43 04/28/18 revealed, that a new order for Haldol/Haloperidol (anti-psychotic) was received by the facility RHWD, but needed clarification. J. On 06/19/18 at 10:00 am, during an interview with the RHWD, she confirmed R #6 did not receive the Haldol ordered by the [name of] hospice nurse on the day Saturday (04/28/18) before she died, because the prescription was written wrong and RHWD was unable to reach the hospice nurse. K. On 06/19/18 at 10:05 am, during a phone interview with DCS #8, she stated that that R #6 was still alive when she arrived to help access her after having an unwitnessed fall in her room on 04/29/18 (exact time unknown). According to DCS #8, R #6's breathing was labored, she seemed agitated, and in pain. DCS #8 stated that the hospice nurse had been called on 04/27/18 and 04/28/18 regarding R #6's increased agitation and pain. L. On 06/23/18 at 2:30 pm, during an interview with DCS #3, he stated that hospice was supposed to get R #6 liquid morphine for pain, the facility only had pills which was were not appropriate for R #6. M. Record review of R #6's April 2018 MAR revealed, an order for Morphine Sulfate/ML (pain/breathing) in liquid form, but is not signed that she ever received the medication.	A 035		
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair	A 042		

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A 042	Continued From page 44 at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.42 Based on record review and interview the facility failed to ensure that the door (near elevator) to the memory care unit was in good repair and automatically locked when closed. This deficient practice has the potential for the 8 (R #s 2-5 and 7-10) residents identified as living in the Memory Care Unit (MCU) identified on the census provided by the Community Relations Associate (CRA) on 06/12/18 to be at risk of harm or injury if the doors are broken and do not automatically lock when closed. The findings are: A. Record review of complaint intake #30541, the complainant reported that around the time of R #1's fall (03/26/18) the mag-lock on the door to the MCU (next to elevator) was broken for several days, allowing residents with Dementia (memory loss) to exit the unit without supervision. B. Record review of a picture (provided by the complainant) of the inside of the MCU door	A 042	A042 Physical Plant Manager (PPM) will monitor all doors in the community monthly and as needed to ensure all doors are in good repair and in proper functioning condition to ensure that safety of all residents. If any malfunctions noted the PPM will address immediately to get in proper working order. ED re- in serviced PPM on new process. PPM will notify ED when doors are not functioning properly to ensure that all residents are not at risk for harm or injury. Continued compliance will be monitored by the ED through quarterly spot audit checks and through annual quality assurance process Corrective Actions will be completed on or before 10-30-18	

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A 042	Continued From page 45 revealed, part of the mag-lock was hanging down and appeared to have been hit, causing it to not automatically lock after being entered or exited. C. Record review of invoice dated 04/20/18 from [name of security company] revealed, that on 03/28/18 a service call was received to fix the mag-lock on the MCU door. According to the invoice it appeared that the lock had been hit. The sub-contractor was able to get the lock to work temporally and on 03/30/18 the lock was replaced. D. On 06/13/18 at 1:15 pm, during an interview with DCS #2, she confirmed that the MCU door was broken for a couple of days after R #1 returned from the emergency room and residents were getting out of the unit.	A 042		
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed	A 068		

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A 068	Continued From page 46 pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s	A 068		

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A 068	Continued From page 47 ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP);	A 068		

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A 068	Continued From page 48 (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC.	A 068		

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A 068	Continued From page 49 (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified. E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits;	A 068		

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A 068	Continued From page 50 (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.68 D (2) (6) Based on record review and interview the facility failed to ensure for 1 (R #6) or 1 (R #6) resident receiving hospice services that: 1. Team meetings were convened prior to admitting and or retaining residents receiving hospice services from an outside agency. 2. Individual Service Plans (ISPs) included coordination of care with the hospice agency. This deficient practice has the potential for residents receiving hospice services to not receive the higher level of care and services they need if: 1. A team meeting is not convened to determine if the resident requires a higher level of care than the facility is able to provide. 2. If there is no coordination of care with the hospice agency, the Direct Care Staff (DCS) will not know what care/services they need to provide and what care/services the hospice agency will provide. The findings are: A. Record review of R #6's resident file revealed,	A 068	A068 The HWD and ED are to ensure that team meetings are being convened prior to admitting and/ or retaining resident receiving hospice services from an outside agency as of 10-17-18. Health and Wellness Director re-inserviced by Regional Director of Health and Wellness, on 10-17-18, that prior to admitting or retaining a resident at the community who is in need of hospice services that a team meeting is conducted to include the following parties, resident, resident legal POA, and outside agency. At time of meeting a new ISP will be developed and signed by all parties. ISP will include outlined and specific services community will be providing and services hospice agency will be providing. Specific to home health aid visits, Nursing visits and coordination of medication orders and receipt of the medications. ISP will be updated every 6 months or change of condition. 2)Compliance will be monitored by the HWD and/or designee by a 100% audit of the Individual Service Plans of resident who receive services from an outside agency (hospice) to ensure that team meetings are being conducted prior to a resident being admitted or retained at the community to a outside agency (hospice). Audits will be done weekly X4 weeks, then 1 time monthly X3 months, then quarterly thereafter. Continued compliance will be monitored by the ED thereafter through quarterly spot audits and through annual quality assurance process. Copies of agencies ISP will be reviewed and initialed by HWD and kept in resident chart and noted in the computer system of its location. ISP will include outlined and specific services community to be provided and services hospice agency will be providing. Specific to home health aid visits, Nursing visits and coordination of medication orders and receipt of the medications. ISP for community will be completed, signed off by HWD, ED, Resident/POA, and reviewed with staff at each shift crossover in detail as to services to be provided. ISP will be entered in computer on the same day signatures were obtained. ED will review ISP's within 24 hours or next business day in the computer to ensure timeliness. Corrective actions will be completed on or before 10-30-18	10-17-18

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A 068	Continued From page 51 no documentation that a team meeting was convened prior to her admission to hospice on 03/22/18. B. Record review of R #6's ISP (dated 03/10/18) revealed, no coordination of care with the hospice agency. C. On 06/18/18 at 2:23 PM, during an interview with the Regional Health and Wellness Director (RH) she confirmed that: 1. A team meeting was not convened prior to R #6 being admitted to hospice services on 03/22/18. 2. That R #6's ISP (dated 03/10/18) did not include coordination of care with the hospice agency. D. On 06/19/18 at 9:00 am, during an interview with the Community Relations Director (CRD), she confirmed the following for R #6: 1. No coordination of care with hospice agency on ISP. 2. No record of a team meeting was convened prior to [Name of Resident] admission to hospice services.	A 068		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary	A 070		

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A 070	Continued From page 52 Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.70 F Refer to 7.1.13.7 W. & 8 B. (2) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health	A 070		

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A 070	Continued From page 53 care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form Based on record review and interview the facility failed to ensure that: 1. Incidents of suspected abuse, neglect, or unusual occurrence were reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. 2. A facility internal investigation was conducted and a follow-up report was submitted to the Licensing Authority within 5 business days of the incident. This deficient practice has the potential for the 41 (R #s 1-41) residents listed on the resident census, provided by the Community Relations Associate (CRA) on 06/12/18, to be at risk of harm, injury, and/or death, if there is no oversite by the Licensing Authority because the facility failed to: 1. Report incidents or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. 2. Submit a follow-up investigation report within 5-business days after the incident. The findings are:	A 070	A070 The ED will complete the online IM Report to DHI within 24 hours of notification of the incident or the next business day when the incident occurs on a weekend or holiday utilizing the incident report form. The website for submission is http://dhi.state.nm.us/imb/imb_irform.php. For electronic submission, to ensure proper receipt of the Incident report, fax a copy of the printed online form with tracking number to 888-572-0012 in addition to submitting it online. If the incident involves ANE. The resident is evaluated by the ED or designee for physical injury and/or any psychological harm that may have occurred as a result of the incident. The community will not delay a report to the complaint hotline while an internal investigation is occurring. Documentation will be kept confidential by the community to the extent required by state law. Copies of reports filed with the state or local law enforcement will be tracked and kept by the community. If the investigation validates the claim, the employee will be terminated and the incident(s) reported to appropriate state department, state licensing board, or law enforcement official. In instances of resident to resident abuse, the aggressive resident may be asked to be immediately moved from the community. The community will submit a written report, "Health Facility Complaint Investigation Five Day Follow-up Report form" to DHI Complaints Units within five (5) days from the date or discovery of the incident. containing the following: 1. a brief narrative description of the incident; 2. the conclusion of the incidents 3. corrective actions and plans to prevent further incidents. HWD and RSC will take part in shift crossover, read documentation in communication book and resident chart to monitor and ensure that any incidents are being documented and investigated immediately	

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	4032	A. BUILDING: _____ B. WING _____	C 06/20/2018

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A 070	Continued From page 54 Findings for R #1 A. Record review of Licensing Authority complaint intake revealed, the facility did not submit an internal investigation report to the Licensing Authority within 5 business days after R #1 was found on the floor on 03/26/18 (unwitnessed fall) in the hallway with her nose bleeding, an abrasion on her forehead, and required transport/treatment in the Emergency Room. B. On 06/13/18 at 12:55 pm, during an interview with the Community Relations Director (CRD), she confirmed based on the records reviewed that no-5-day follow-up internal investigation report was sent to the Licensing Authority for R #1's unwitnessed fall with injury on 03/26/18. Findings for R #s 2 & 3 C. On 06/13/18 at 11:20 am, during an interview with [name of Ombudsman (resident advocate)], she reported that on [redacted]18, R #2 hit R #3 in the face and the incident of resident to resident abuse was not reported to the state. D. Record review of R #2's progress notes revealed: 1. On [redacted]/18 at 9:14 pm, R #2 was highly agitated and had an altercation with another resident (resident-resident abuse) that became physical. 2. On [redacted]/18 at 10:24 pm, R #2 was in an altercation (verbally/possibly physical) with R #3. R #2 was attempting to enter R #3's room, R #3 began shouting for R #2 to leave. R #2 was holding the door handle, while banging on the door. Direct Care Staff (DCS) #5 was able to	A 070	A070 continued Community Staff will immediately (within 24 hours) report a resident's condition that might indicate the above incidents to the Executive Director (ED) or designee. However, any person may report an incident to the bureau by utilizing the DHI toll free complaint hotline at 1-800-752-8649. The staff member with direct knowledge of the incident must immediately fill out an Incident Report Form and turn in to the ED or designee. iThe ED will complete the online IM Report to DHI within 24 hours of notification of the incident or the next business day when the incident occurs on a weekend or holiday utilizing the incident report form. The website for submission is http://dhi.state.nm.us/imb/imb_irform.php. For electronic submission, to ensure proper receipt of the Incident report, fax a copy of the printed online form with tracking number to 888-572-0012 in addition to submitting it online. If the incident involves ANE The resident is evaluated by the ED or designee for physical injury and/or any psychological harm that may have occurred as a result of the incident. The community will not delay a report to the complaint hotline while an internal investigation is occurring. Ensure the resident is safe or seek medical care as necessary. For resident-to-resident abuse, separate the residents until the situation can be investigated. If a resident cannot be controlled contact the police. The ED will Initiate an investigation of known or alleged acts of ANE immediately upon witnessing the act or upon receipt of the allegation or upon having cause to believe ANE occurred; If there is a cause to believe ANE of the resident has occurred by a staff member, the staff member will be suspended pending investigation. The ED or designee interviews the individual making the allegation, the resident(s) involved, and the alleged perpetrator(s), if applicable within five (5) days. Additionally, interviews staff members who were on duty at the time of the alleged/suspected abuse. Interviews will be: Conducted in a private place with discussions confidential.	

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A 070	Continued From page 55 redirect R #2 back to [redacted] room. DCS #5 noted that she did not see R #2 hitting or raising [redacted] hands to R #3. The police were called at R #3's request. E. Record review of R #3's progress notes revealed: 1. On [redacted]18 at 10:17 pm, R #3 was involved in an altercation with R #2. DCS #5 heard a lot of banging and some yelling. DCS #5 saw R #2 standing in R #3's doorway and R #3 was shouting at R #2 to leave [redacted] room. DCS #5 was able to redirect R #2 back to [redacted] room. When DCS #5 went back to check on R #3, [redacted] was shaken and stated that R #2 had hit [redacted] DCS did not see any sign of injury from the altercation. The police were called at R #3's request. 2. On [redacted]18 at 3:48 pm, R #3 was observed by DCS #5, provoking and poking R #2 in the shoulder numerous times asking R # 2 how [redacted] liked being hit. R #3 was asked to return to [redacted] room and [redacted] did. 3. On 05/12/18 at 10:24 pm, R #3 was involved in an altercation with another resident (name unknown) that struck her in the neck and throat. F. Record review of R #s 2 & 3's resident files revealed, no documentation that the resident to resident abuse incidents were reported to the Licensing Authority. G. On 06/19/18 at 12:34 pm, during an interview with Community Relations Director (CRD), Community Relations Associate (CRA), and the Health and Wellness Director (HWD), they confirmed that the facility did not report the incidents of resident to resident abuse for R #s 2 & 3 to the Licensing Authority.	A 070	A070 continued The content of the interviews are documented with a witness present. The community will report findings and intentions to report the suspected abuse to the resident's primary healthcare provider. The documentation of the incident will maintain evidence that all alleged violations are thoroughly investigated prior to reporting to DHI. Documentation will be kept confidential by the community to the extent required by state law. Copies of reports filed with the state or local law enforcement will be tracked and kept by the community. If the investigation validates the claim, the employee will be terminated and the incident(s) reported to appropriate state department, state licensing board, or law enforcement official. In instances of resident to resident abuse, the aggressive resident may be asked to be immediately moved from the community. The community will submit a written report, "Health Facility Complaint Investigation Five Day Follow-up Report form" to DHI Complaints Units within five (5) days from the date or discovery of the incident. containing the following: 1 a brief narrative description of the incident; 2 the conclusion of the incidents 3 corrective actions and plans to prevent further incidents Continued compliance will be monitored by the ED and/or designee through the quarterly assurance process. Corrective Actions will be completed on or before 10-30-18.	

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A 070	Continued From page 56 Findings for R #6 H. Record review of R #6's resident file revealed, a completed incident report (state form) for an unwitnessed fall on 03/20/18 where R #6 broke her wrist. There was no documentation that the report was sent to Licensing Authority. I. On 06/14/18 at 1:12 pm, during an interview with the Complaint Supervisor/Licensing Authority, she confirmed that no report was received for R #6's unwitnessed fall with injury (broken wrist) on 03/20/18. J. Record review of the facility's internal incident report (dated 04/29/18) for R #6 for an unwitnessed fall where she died soon after (unusual occurrence) revealed, no documentation that the incident was reported to the Licensing Authority. K. On 06/19/18 at 9:00 am, during an interview with the Community Relations Director (CRD), she confirmed that there was no documentation that the incident report completed for R #6's fall (broken wrist) was sent to the Licensing Authority. L. On 06/20/18 at 1:34 pm, during an interview with the Regional Health and Wellness Director, she confirmed that there was no incident report for R #6's unwitnessed fall on 04/29/18 (died after fall) sent to the Licensing Authority.	A 070		