PRINTED: 01/21/2009
FORM APPROVED

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5772	A. BUILDING _____ B. WING _____	07/16/2008

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

(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
A11	7 NMAC 8.2.11 Survey/ Monitoring Visits 7.8.2.11 SURVEY/MONITORING VISITS: A. The Licensing Authority shall perform on-site survey/monitoring visits at all adult residential care facilities to determine compliance with these regulations, to investigate complaints, or to investigate the appropriateness of licensure for any alleged unlicensed facility. B. The facility must provide the Licensing Authority access to any material and information necessary for determining compliance with these requirements. C. The most recent survey inspection reports and related correspondence shall be posted in a conspicuous public place in the facility. D. Failure by the facility to provide the Licensing Authority access to premises or information, including resident records, may result in the imposition of sanctions, or license revocation. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.11 NMAC - Rn, 7 NMAC 8.2.11, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.11 C. . . . most recent survey . . . posted in a conspicuous public place . . . Based on observation and interview the facility failed to have the most recent survey posted in a conspicuous public place in the facility. The findings are: A) Tour of the facility on 7/1/08 at 7:45 AM and at 8:20 AM, there was no survey observed posted in the facility. B) In an interview with the administrator on 7/2/08 at 2:35 PM, the administrator presented	A11	A 11 An additional wall rack has been placed by the main entrance/ office to hold the survey reports. The reports are labeled in a binder and the wall rack is also labeled and separate from other facility forms.	7/18/08

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Division of Health Improvement

Ronda Cole — TITLE Director — (X6) DATE 2/3/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM NHPU11 If continuation sheet 1 of 33

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A11	Continued From page 1 the facility's most recent survey report and said it was suppose to be in the front room by the entrance door, but she found it in the Medication Room. The residents and the public do not have access to the Medication Room. C) Tour of the facility on 7/7/08 at 6:46 AM, the facilities most recent survey report was found in the back of a wall rack with facility forms covering it from sight, therefore the survey continued to not be posted in a conspicuous place.	A11		
A13	7 NMAC 8.2.13 Grounds for Revocation or Suspension of Licen 7.8.2.13 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES: A. When the Licensing Authority determines that an application for renewal of a license is to be denied, or that a license is to be revoked, the Licensing Authority shall provide written notification to the adult residential care facility, the residents of the adult residential care facility and the surrogate decision maker for the resident. B. A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following reasons: 1. Failure to comply with any provision of these regulations. 2. Failure to allow a survey by authorized representatives of the Licensing Authority. 3. Hiring or retaining any employee who	A13		

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A13	Continued From page 2 has been convicted of a felony or misdemeanor related to abuse, neglect or exploitation, trafficking in controlled substances, criminal sexual penetration or related sexual offenses. 4. Misrepresentation or falsification of any information on application forms or other documents provided to the Licensing Authority. 5. Discovery of repeat violations of these regulations. 6. Failure to provide the required care and services as outlined by these regulations for the residents receiving care from the facility. 7. Exceeding licensed capacity. 8. Failure to provide an acceptable plan of correction. 9. Abuse, neglect or exploitation of any patient/client/resident by facility operator, staff or relatives of operator/staff. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 6-15-98; 7.8.2.13 NMAC - Rn, 7 NMAC 8.2.13, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.13 B. (1) Failure to comply with any provision of these reglations. Refer also to 7.8.2.36 G. Medications removed for the pharmacy container . . . given immediately. . . Based on observation and interview the facility failed to insure medications removed from the pharmacy container were given immediately for 2 of 2 residents (R2 & R3). The findings are: A) Observation on 7/7/08 at 7:12 AM, staff S56 removed a pre-drawn syringe of insulin from the medication refrigerator and went to resident R3's	A13	A 13 A-H Those residents currently residing will have the option of: 1. Converting to insulin pins or pill form 2. Contract with Home Health to come to the facility to draw and administer their insulin 3. As a last result, the facility will discharge the resident. The administrator will begin contacting family members and/or Doctors regarding the changes to take place. Prior to any new admissions, when the Administrator and facility nurse conduct an assessment, the team discussion will include diabetic regulations for those who are diabetic.	2/16/09

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A13	Continued From page 3 room and assisted with the medication administration. B) Observation on 7/7/08 at 7:26 AM, staff S56 removed a pre-drawn syringe of insulin from the medication refrigerator and went to resident R2's room and assisted with the medication administration. C) In the first interview with staff S56 on 7/7/08 at 7:24 AM, staff S56 acknowledged the facility's nurse pre-draws a one week supply of insulin into syringes for residents R2 and R3. D) In the first interview with the administrator on 7/7/08 at 2:34 PM, the administrator acknowledged the facility's nurse pre-draws insulin into a one week (7 days) supply of pre-drawn syringes for residents' R2 and R3 and all other insulin dependent residents are injected by nurses from an outside home health agency. E) In the second interview with the administrator and staff S56 on 7/14/08 at 10:48 AM, the administrator now stated that resident R3's daughter pre-draws insulin every Sunday into a one week (7 days) supply of pre-drawn syringes for resident R3. F) In an interview with the facility's nurse on 7/16/08 at 2:21 PM, the nurse acknowledged she pre-draws syringes of insulin for a one week supply of injections for resident R2. G) Observation of the medication refrigerator on 7/16/08 at 2:38 PM revealed a one week supply of pre-drawn syringes for resident R3. The syringes were pre-drawn for a sliding scale as prescribed by the physician. On the sliding scale resident R3 receives 0, 4, 6, 8, or 10 units of	A13		

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A13	Continued From page 4 Humalog Slide 4 times a day depending on blood sugar levels. Resident R3 also receives 1 injection a day of Humulin N. This equals 119 syringes to cover a one week period if all possibilities on the sliding scale are allowed for. This represents 119 possibilities for medication errors. H) There was also a one week supply of pre-drawn syringes of insulin marked for resident R2. Resident R2 receives 5 injections a day. That is 35 syringes for a one week supply. Based on record review and interview the facility failed to provide access to pain medication for resident R9. This caused the resident to suffer a higher level of pain than normal. The findings are: A) Record review on 7/3/08 revealed a physician's admission examination for resident R9. Resident has a history of chronic obstructive pulmonary disease, gastroesophageal reflux disease, hypertension, benign prostatic hypertrophy, peripheral neuropathy, 4 back surgeries, right side total knee replacement, right hip nailing, and right side hernia. A medical referral signed by the physician for resident R9 dated 4/3/08 was for chronic back pain. B) Record review on 7/3/08 of the April, May, and June 2008 Medication Administration Record (MAR) for resident R9 revealed several blanks. The blank spaces should have recorded given, missed, or refused medication administration. Start dates and times were sometimes one day off when comparing the start of a medication to the Individual Resident Narcotic Record.	A13	A 13 A-G At the time of the survey all over flow/extra medications and dis-continued medications were stored in a locked cabinet in the Administrator's office. Only the Administrator and two other Team Leaders had access to the office. A locked cabinet for these medications is now in the Med Room where the Med Tech on duty has access to it at all times. Administrator has developed a monitoring system for review of MAR's and narcotic records. (these forms are attached to report) Every day at the beginning and end of every shift all Med Techs count all narcotics with an on coming Med Tech. They all sign to verify accuracy. Cont.	7/7/08 10/8/08

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A13	Continued From page 5 Therefore the MAR could not be used for an accurate medication recapitulation. C) Record review on 7/3/08 revealed two physician's prescription dated 5/15/08. One was for Opana ER 40 mg 1 to 2 tabs every 8 hours. The other was for Opana IR 10 mg 1 to 2 tabs every 8 hours as needed (PRN). The Individual Resident Narcotic Record revealed that resident R9 had been taking two 40 mg tabs (80 mg) of the Opana ER every 8 hours and 1 to 2 tabs of the Opana IR every 8 hours in between the doses of Opana ER. D) In an interview with resident R9 on 7/1/08 at 3:25 PM, resident R9 stated, "The facility has run out of my pain medication. The refills are locked up in the administrator's office. The staff have no access to the office when the administrator and [staff 55] aren't here. I wish the Doctor would have prescribed the Opana IR 10 mg as a regular scheduled dose instead of PRN. I take the Opana IR 10 mg in between times of the [regularly scheduled] Opana ER [40 mg]. I ask for it sometimes and don't get it." Resident R9 further stated he has missed his scheduled doses of Opana 40 mg and his PRN Opana 10 mg approximately 6 times. He stated he had 4 back surgeries and one leg is shorter than other and said, "I have excruciating pain in my lower back. My pain level goes way up when out of Opana and it takes awhile for it to take effect when restarted." Resident R9 said, "The first or second week in May, I told [staff S57] I need my oxycodone. [Staff S57] told me the Doctor discontinued it, it is locked up in the office, and the Opana has not arrived yet." Resident R9 acknowledged he got mad at staff S57 and the administrator was	A13		

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A13	Continued From page 6 called. The administrator came to the facility. Resident R9 said, "[Administrator] told me, 'If you [R9] ever tear into a staff again, you [R9] will be on the curb so fast your head will spin." During this interview resident R9 demonstrated good cognitive abilities by knowing the day of the week, date, and the staff names at the facility. Resident R9 was able to state all of his diagnoses and knew which medication he takes for each diagnosis. E) Review of the May and June 2008 "Individual Resident Narcotic Record" on 7/3/08 for resident R9 of the Opana ER 40 mg revealed the following scheduled doses were missed: 1. 5/17/08 at 1400 (2:00 PM) 2. 5/24/08 at 1400 (2:00 PM) 3. 5/29/08 at 1400 (2:00 PM) 4. 6/17/08 at 1400 (2:00 PM) 5. Between 6/27/08 at 1400 (2:00 PM) and 6/30/08 at 0600 (6:00 AM) a dose was missed, but it is impossible to reconcile exactly when, due to inaccuracy of the times and dates. 6. Resident R9 missed scheduled doses of Opana ER 5 times in a one and a half month period. F) Review of the May 2008 "Individual Resident Narcotic Record" on 7/7/08 for resident R9 of the Opana IR 10 mg revealed the following: 1. Opana IR 10 mg was administered on 5/17/08 at 1800 (6:00 PM) 4 hours after the missed regularly scheduled dose of Opana ER 40 mg. 2. Opana IR 10 mg was administered on 5/24/08 at 1700 (5:00 PM) 3 hours after the missed regularly scheduled dose of Opana ER 40 mg. 3. Opana IR 10 mg was administered on 5/29/08 at 1700 (5:00 PM) 3 hours after the missed regularly scheduled dose of Opana ER 40 mg. 4. Opana IR 10 mg was administered on 6/17/08	A13	This form is then turned into the Administrator daily for review of completion. Every week the Administrator reviews the MAR's for any blanks and signs and dates when complete. If blanks are found, Med Tech responsible is counseled. 1st occurrence: Written warning 2nd occurrence: Suspension 3rd occurrence: Termination In addition, facility nurse also reviews the MAR's and narcotic logs at least monthly or more often if necessary and signs and dates when reviewed. Any blanks are reported to the Administrator for review and appropriate counseling to the responsible Med Tech. Administrator will begin daily review of narcotic logs to ensure accurate count and dose given. Administrator will sign off after review of logs. Cont.	2/10/09

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A13	Continued From page 7 at 1700 (5:00 PM) 3 hours after the missed regularly scheduled dose of Opana ER 40 mg. G) In an interview with the administrator on 7/16/08 at 4:00 PM, this surveyor asked the administrator to explain the disagreement with resident R9 on 5/16/08. The administrator acknowledged the physician discontinued oxycodone for resident R9' and the new prescription for Opana ER had not arrived at the facility. The administrator said, "I had to call the doctor and get authorization to continue the Oxycodone. The oxycodone was continued until the Opana arrived." This surveyor asked the administrator, "What did you say to Resident R9 when he expressed frustration with not getting his medication for pain?" The administrator said, "I told him that is non-acceptable behavior and if he does it again he can't live at [facility name]." This surveyor asked the administrator if this is an exact quote and she repeated the exact same statement.	A13	A 13 Cont. Facility nurse and Administrator will also conduct an in –service for all Med Techs covering the additional information on the daily reports that are turned into the Administrator. Med Techs will be required to also review all narcotic logs to determine that all narcotics were given at the correct time and correct dose. This is included on the form (attached) that is turned into the Administrator daily.	2/10/09
A23	7 NMAC 8.2.23 Fac, reports, Recs., P & RS & Rules 7.8.2.23 FACILITY REPORTS/RECORDS/POLICIES AND PROCEDURES/ AND RULES: A. REPORTS AND RECORDS: Each facility must keep the following reports, records, and policy and procedures on file at the facility and make them available for review upon request of the Licensing Authority: (1) Fire Inspection Report. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have fire inspection reports. (2) Copy of the last survey conducted by the Licensing Authority, adverse actions or	A23		

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A23	Continued From page 8 appeals thereto, and complaints. (3) Copy of the latest survey from Environmental Health Authority (if applicable) regarding kitchen and food management and, if private sewage disposal, and private waste disposal. EXCEPTIONS: Adult residential care facilities with three (3) or fewer residents are not required to be inspected by Environmental Health Authority. Facilities exempted by the Environmental Health Authority having jurisdiction, are not required to have a survey on file provided the exemption letter is on file. (4) TB test results of staff or any of their family members living in the facility. (5) One (1) month of menus planned and as served. (6) Record of fire drills: A record of all fire drills conducted at the facility. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to hold or record fire drills. (7) Written emergency plans and policies and procedures for medical emergencies, power failure, fire or natural disaster. Such plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes and refuge areas, responsibilities of personnel. (8) Licensing regulations: A copy of these regulations (Requirements for Adult Residential Care Facilities, 7.8.2 NMAC). (9) Custodial Drug Permit: A valid Custodial Drug Permit issued by the State Board of Pharmacy for those facilities licensed pursuant to these regulations. EXCEPTION: Adult residential care facilities with only one (1) resident are not required to have a custodial drug permit. (10) Vaccination of pets in the facility. (11) Staff training. (a) At orientation and on-going.	A23		

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A23	Continued From page 9 (b) Appropriate to staff responsibilities. (Assistance with medications, dietary, environmental...) (c) Fire safety. (d) First aid. (e) Safe food handling practices. (f) Confidentiality of records and resident information. (g) Infection control (including universal precautions and linen handling). (h) Resident rights. (i) Providing Quality Resident care based on current resident need. (j) Reporting requirements for Abuse, Neglect or Exploitation. (12) A copy of License. (13) Employee personnel records, including an application for employment, TB certificates, training records, and personnel actions. (14) A copy of all WAIVERS/VARIANCES granted by the Licensing Authority. (15) A copy of the floor plans as approved for licensure. B. RULES: Prior to placement in or admission to a facility, a prospective resident or his/her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to but not limited to the following: (1) The use of tobacco and alcohol. (2) The use of the telephone. (3) Operation of television, radio, and stereo. (5) Use and safekeeping of personal property. (6) Meals. (7) Use of common areas. (8) Electric blankets or appliances used by residents. C. POLICIES AND PROCEDURES: All	A23		

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A23	Continued From page 10 facilities shall have written policies and procedures covering the following areas: (1) Actions to be taken in case of accidents or emergencies, (e.g., gas leaks, injuries, transportation, medications,...). (2) Method of keeping informed when residents go outside of the facility (e.g., sign-out sheets). (3) The handling or resident's funds, if the facility provides such services. (4) Reporting of incidents, including abuse, neglect, and exploitation. (5) Handling of complaints. (6) Staff and resident fire and safety training. (7) Smoking. (8) The facility's bed hold policy. (9) Admission agreement. (10) Admission records. (11) Resident records. (12) Program Narrative. (13) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (14) Personnel policies. (15) Identifying and safeguarding resident possessions. (16) Securing medical assistance if a resident's own physician is not available. (17) NOTE FOR MATERNITY SHELTERS ONLY: In addition to the required policy and procedure topics listed above, Maternity Shelters shall have written policies and procedures regarding infant formula, feeding and equipment, and laundering of infant linen and diapers. (18) Staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles.	A23		

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A23	Continued From page 11 (19) Staff training for employees who operate motor vehicles to transport residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.23 NMAC - Rn & A 7 NMAC 8.2.23, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.23 A. (11) Staff training This is a repeat deficiency from survey dated 12/27/06. Based on record review and interview the facility failed to have documentation of staff training for 3 of 4 staff files reviewed (S59, S64, & S72). The findings are: A) Record review on 7/8/08 of the staff files revealed no documentation that staff S59, S64, and S72 received the following trainings: 1. Safe food handling, 2. Confidentiality of records, 3. Infection control, 4. Residents rights 5. Quality care based on resident needs, 6. Incident reporting, or 7. Transportation assistance and/or vehicle operation. 8. There was also no documentation of training for First Aid for staff S72 and no documentation of Fire safety training for staff S59 or S64. B. In an interview with the administrator on 7/8/08 at 3:00 PM, the administrator did not present any further documentation of staff training.	A23	A 23 The Administrator has put into effect a record of all required trainings for staff. A list of these trainings is placed in a note book labeled In Services. In addition, there is a list of all required trainings in all staff charts, each signed by staff members and dated by Administrator upon completion of each training. Administrator will conduct quarterly chart reviews using the attached audit forms to ensure that all required staff documentation is current.	1/1/09
A34	7 NMAC 8.2.34 Resident Rights 7.8.2.34 RESIDENT RIGHTS: All licensed facilities shall be aware of, protect, and enhance	A34		

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A34	Continued From page 12 the rights of all residents. A. Prior to admission to a facility, a resident and/or legal representative shall be given a written description of the legal rights of the residents translated into another language, if necessary, to meet the residents understanding. B. If the resident is incapable of understanding his/her legal rights, and if he/she has no legal representative, then the licensee shall also give a written copy of the resident's legal rights to one of the following persons, in this order of priority: (1) the resident's spouse; (2) any of the resident's adult children; (3) either of the resident's parents; (4) any relative the resident has lived with for six or more months before admission; (5) a person who has been caring for, or paying benefits on behalf of the resident; (6) a placing agency; or (7) any other person, e.g., Ombudsman. C. These resident rights and the telephone number for the Ombudsman Program shall be posted in a conspicuous place in the facility: D. The facility, to protect resident rights must: (1) Treat all residents with courtesy, respect, dignity and compassion. (2) To the extent that resident required services fall within the scope of the facilities program, avoid discrimination in admission or services because of a resident's age, race, religion, physical or mental disability, or nationality. (3) Furnish residents written information about all services provided by the facility and their costs, and advance written notice of any changes. (4) Assure that residents have a safe and sanitary living environment.	A34		

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A34	Continued From page 13 (5) Provide humane care. (6) Assure the resident's rights to privacy in medical care, including privacy during medical examinations, consultations and treatment; and protect the confidentiality of the resident medical records. (7) Protect and assure the resident's 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. (8) Assure the resident's right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and assure the resident's right's to receive visits from family, friends, lawyers, ombudsmen and community organizations. (9) Prohibit the use of any and all physical and chemical restraints. (10) Assure the residents are free from physical and emotional abuse and neglect. (11) Assure that all residents are free from financial abuse and exploitation by facility staff and/or management. (12) Consistent with the resident's health, abilities and security, assure the right of the resident to freely participate in religious, social, community and other activities; and freely associate with persons in and out of the facility. (13) Permit the residents to leave the facility freely and return without unreasonable restriction. (14) Prevent unjustified room transfers or discharge from this facility. (15) Use care and management practices that foster social interaction and avoid practices that unnecessarily result in social isolation. (16) Provide services consistent with	A34		

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A34	Continued From page 14 informed consent. (17) Assure that all residents may voice grievances to the facility staff, public officials, the ombudsmen or any other person, without fear of reprisal or retaliation. (18) Promptly address and resolve resident complaints. (19) Foster resident participation and understanding in the development, review and modification of the resident's plan for care and treatment. (20) Respect a resident's choice of doctor, pharmacist and other health care provider. (21) Respect a resident's medical treatment decisions and advance directives, such as living wills and durable powers of attorney for health care. (22) Respect a resident's right to keep and use personal possessions without loss or damage. (23) Allow each resident to manage and control the resident's personal finances to the extent that the resident is able, and provide to every resident a written record of all financial arrangements and transactions involving that resident's funds. (24) Allow residents to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management. (25) Require no resident to work for the facility. (26) Consult with the incapacitated resident regarding his/her care, regardless of the involvement of a guardian or surrogate decision maker. (27) Assure the involvement in, and consent of, an incapacitated resident's guardian or surrogate decision maker in the resident's	A34		

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A34	Continued From page 15 care. E. The resident's rights shall not be restricted unless the resident agrees to such a restriction, and unless this restriction is described in detail in his/her individual service plan. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.34 NMAC - Rn, 7 NMAC 8.2.34, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.34. D. (4) Safe and Sanitary living environment Based on observation and interview the facility failed to provide a sanitary living environment for 39 of the facility residents (R1 through R39). The findings are: A) Tour of the facility on 7/1/08 from 8:01 AM to 8:25 AM, staff S64 was observed to not change gloves during assistance with medication administration for residents R1 through R26. During this time staff S64 handled medications, glasses of water, glasses of juice, and residents' unclean used breakfast dishes. Staff S64 was sticking his finger inside medication containers to remove the medications touching them all with the same pair of gloves. B) In an observation on 7/7/08 at 8:11 AM, staff S64 was observed assisting with medications in the Memory Care Unit of the facility. Staff S64 handled the medications and never changed gloves during the assistance with medication administration for residents' R27 through R39. C) In an interview with staff S64 on 7/15/08 at 10:34 AM, staff S64 acknowledged he handles the residents' medications, glasses of juice and water, and touches other items without changing gloves.	A34	A 34 Facility nurse will conduct an in service/re- training for all Med Techs on the required use of gloves and changing of gloves between each resident's med pass. Training will also cover sanitary and cross contamination procedures. All Med Techs will attend this training, sign and date that they have attended and will follow the procedure. Documentation will be in personnel file. Continuous observation will be made by the Administrator and facility nurse in conjunction with Adobe staff	2/10/09

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A34	Continued From page 16 D) In an observation on 7/7/08 at 7:12 AM, staff S56 handed resident R3 a syringe and did not offer any means of sanitizing the skin at the injection site. Resident R3 self administered the injection without any sanitizing of the injection site. E) In an observation on 7/7/08 at 7:26 AM, staff S56 handed resident R2 a syringe and did not offer any means of sanitizing the skin at the injection site. Resident R2 self administered the injection without any sanitizing of the injection site. F) In an interview with staff S56 on 7/16/08 at 2:35 PM, staff S56 acknowledged not offering resident R2 or R3 any means of sanitizing the skin at the injection site. G) Tour of the facility on 7/7/08 at 10:08 AM, a room accessible from an outside door only was observed to house a hot water heater and an ice machine which revealed the following: 1. The room was encrusted with dirt to the point the floor was not visible through the dirt around the ice machine, 2. There were spider webs all around the window, and 3. The top of the ice machine was encrusted with dirt and an ice scoop was setting on it. H) In an interview with staff S64 at 2:24 PM, this surveyor ask staff S64 what he thought of the room and he replied, "It's pretty nasty." This surveyor asked staff S64 if he would want to have a drink with ice from this machine and he replied, "No." This surveyor asked staff S64 if ice from this machine is served to the residents and he replied, "The cooks get ice for the residents from	A34	A 34 D-F Administrator or Lead Med Tech will complete a weekly supply list to be turned into Corp. Office for any supplies needed, to include alcohol prep pads which are used by residents to sanitize the area prior to finger sticks and injection of insulin. Administrator or Lead Med Tech will make sure there is always a supply of alcohol prep pads. A 34 G Administrator has designated the cleaning staff to keep the ice machine/water heater area clean and free from dirt and spider webs. On a weekly basis that area will be cleaned, swept and mopped. Cleaning staff will initial that the duties have been completed weekly. This will remain posted in the ice machine/water heater area. Administrator will monitor these duties weekly for completion. Cont.	7/17/08 7/12/08

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A34	Continued From page 17 here." I) In an interview with the administrator on 7/11/08 at 8:15 AM, the administrator was asked to observe the ice machine and the room it is located in. This surveyor asked the administrator if she would want to have a drink with ice from this machine and the administrator replied, "Not really." J) Tour of the facility's Memory Care Unit on 7/7/08 at 8:22 AM, staff S64 was observed to crush medication tablets in a pill crusher without cleaning or sterilizing the crusher before or after use. K) Tour of the facility's Memory Care Unit on 7/15/08 at 10:34 AM, the pill crusher for powdering medication tablets was observed to have white powder in it. L) In an interview with staff S64 on 7/15/08 at 10:34, staff S64 acknowledged not cleaning the pill crusher before or after use and that there is powdered medications left in the pill crusher. Staff S64 further acknowledged the crusher only gets cleaned by the cleaning staff once a week and the pill crusher was used everyday.	A34	A 35 J Cleaning of the pill crusher will be conducted after each use. All Med Techs will be in serviced on the proper use and cleaning of the pill crusher. Documentation of such training will be in each Med Tech personnel file and the in service log book. Cleaning instructions for the pill crusher will be incorporated into the Assisting With Medications Training certification.	2/10/09
A35	7 NMAC 8.2.35 Custodial Drug Permit 7.8.2.35 CUSTODIAL DRUG PERMIT: Any facility licensed pursuant to these regulations who supervises the administration, self-administration, or safeguards medications for residents, must have a current custodial drug permit issued by the State Board of Pharmacy. EXCEPTION: Adult residential care facilities with one (1) resident are not required to have a custodial drug permit.	A35		

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A35	Continued From page 18 A. PROCUREMENT, LABELING, AND STORAGE: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as required by the individual or specified by the individual's health care plan. The facility shall procure, label, and store medications for residents in a manner which shall be in compliance with state and federal laws. (1) All medications, including non-prescription drugs, will be stored in a locked compartment or in a locked room, as approved by the Board of Pharmacy, and the key will be in the care of the director or designee. (2) Internal medication must be kept separate from external medications. Drugs to be taken by mouth will be separated from all other dosage forms. (3) A separate locked compartment will be available in the refrigerator for those items labeled "keep in refrigerator." The refrigerator temperature will be kept between thirty-five (35) and forty-five (45) degrees Fahrenheit. A thermometer is required to be kept in the refrigerator. (4) All medications, including non-prescription medications, must be stored in separate compartments for each resident and all medications will be labeled with the residents' names. (5) A resident may be permitted to keep his/her own medication in a secure place in his/her room for self-administration if the physician's report has deemed it appropriate that the resident do so. (6) The facility may not require the resident to purchase prescriptions from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of	A35		

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A35	Continued From page 19 inhalation therapy and for resuscitative purposes must comply with National Fire Protection Association (NFPA) 99. B. CONSULTING PHARMACIST: The facility shall maintain records demonstrating the consulting pharmacist provides the following: (1) Reviews the medication regimen as needed, but at least quarterly (every three (3) months), to determine that all medications and records are accurate and current. All irregularities must be reported to the Director of the facility and these irregularities must be acted upon. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation is provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. [7-1-64, 9-15-70, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.35 NMAC - Rn, 7 NMAC 8.2.35, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer 7.8.2.35 A. (1) Medications . . . stored in locked compartment . . . Based on observation and interview the facility failed to keep medications in compartments that were locked. The findings are: A) In a tour of the facility on 7/1/08 at 8:16 AM to 8:18 AM and at 8:47 AM to 8:50 AM, the medication cart containing residents' medications was observed left unlocked and unattended in the dining room. The residents were eating breakfast	A35	A 35 A-C In service/re-training will be conducted for all Med Techs regarding the required importance of keeping the med cart locked and not leaving the keys unattended. They will remain in the hands of the Med Tech only. Documentation of such training will be signed and placed in Med Tech personnel file and in the in Service log book. Disciplinary action will be as follows: Med Tech responsible is counseled. 1st occurrence: Written warning 2nd occurrence: Suspension 3rd occurrence: Termination Administrator and facility nurse will make random observations and inquiries as to the location of the med cart keys.	2/10/09

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A35	Continued From page 20 in the dining room at these times with no staff in sight of the medication cart. B) Tour of the facility's Memory Care Unit on 7/7/08 at 10:24 AM, staff S64 was observed outside the Memory Care Unit leaving the medication cart unlocked with his keys laying on top of the cart. There were three residents left in the room with the unlocked medication cart. C) In an interview with staff S64 on 7/15/08 at 10:34 AM, staff S64 acknowledged he has left the medication cart containing residents' medications unattended and out of his sight without locking the cart when the residents were present in the room with the cart. Staff S64 further acknowledged leaving his keys on the cart which includes a key to the narcotics storage. D) During tour of the facility on 7/16/08 at 3:49 PM, The door to medication room was open and there was no staff in the room or in sight of the room. The refrigerator in this room was not equipped with a means of locking and residents' medications that need refrigeration were stored in this refrigerator. Staff S57 returned to the medication room at 3:51 PM. E) In an interview with staff S57 on 7/16/08 at 3:51 PM, staff S57 acknowledged she had left the room unlocked and unattended and further acknowledged the medication refrigerator was not equipped with a lock.	A35	A 35 In service/retraining for all Med Techs will be conducted regarding the Med room door not being left open and unattended. In addition, the medication in the refrigerator located in the med room will be equipped with a lock for any medications requiring refrigeration. The key will be in the possession of the Med Tech. Administrator and facility nurse will make random observations as to the refrigerator being locked.	2/10/09
A36	7 NMAC 8.2.36 Medications 7.8.2.36 MEDICATIONS: Medications will be administered or staff assistance with medications provided and documented in accordance with state and federal laws.	A36		

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A36	Continued From page 21 A. Licensed health care professionals are responsible for the administration of medications. B. Facility staff may assist a resident with medications if written consent by the resident is given to the director of the facility or their designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with medications. All staff assisting with medications shall have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications. C. No medications, including over the counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order by the physician and entry into the resident's record. D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and side-effects. E. Medications prescribed for one resident shall not be used for another resident. F. The facility shall have a Medication Administration Record (MAR) documenting medications administered to residents, including over-the-counter medications. This documentation shall include: (1) Name of resident. (2) Date started. (3) Drug product name. (4) Dosage and form. (5) Strength of drug. (6) Route of administration (e.g. "by mouth"). (7) How often medication is to be taken.	A36		

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A36	Continued From page 22 (8) Time taken and staff initials. (9) Dates when the medication is discontinued or changed. (10) The name and initials of all staff administering medications. G. Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting. H. PRN Medications: The use of PRN medications must be closely monitored and supervised by the facility and is based on one or more of the following conditions: (1) The resident is capable of determining when the medication is needed. (2) The resident's physician has provided detailed instructions to the pharmacy regarding the administering of the medication. The physicians instruction for a PRN medication shall include: (a) Symptoms that might indicate the use of the medication. (b) Exact dosage to be used. (c) The exact amount of medication to be used in a 24 hour period. (d) Directions as to what to do if the symptoms persist. (e) Possible interactions or side-effects that might occur. (f) Manufacturer's label information for directions if deemed adequate by the physician. I. The facility must report all medication errors to the physician. J. The facility shall develop and follow a written policy for unused, outdated, or recalled medications being kept in the facility. [7-1-64, 9-15-70, 7019074, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.36 NMAC - Rn, 7 NMAC 8.2.36, 8-31-00] This REQUIREMENT is not met as evidenced	A36		

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	5772	A. BUILDING _____ B. WING _____	07/16/2008

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

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A36	Continued From page 23 by: Refer to 7.8.2.36 D. . . . medication reference material . . . Based on record review and interview the facility failed to have reference material on at least 2 medications prescribed for resident R9. The findings are: A) Record review on 7/8/08 of facilities "Nursing Handbook 2004" revealed that Oxycodone ER and Opana ER are not listed in the book. No other medication reference material was observed. Review of resident R9's records revealed he had been prescribed these medications while residing at the facility. B) In an interview with staff S56 on 7/8/08 at 2:47 PM, staff S56 acknowledged the pharmacy does not send reference material with the prescriptions and the "Nursing Handbook 2004" is all that is available at the facility. Staff S56 further acknowledged the facility does not have internet service to access medication reference material. This surveyor asked staff S56 if she knew what the side effects of Opana ER are. She replied no and proceeded to look up the Opana ER in "Nursing Handbook 2004." Staff S56 acknowledged that the Opana ER was not listed in the Nursing Handbook 2004. Refer to 7.8.2.36 F. Medication Administration Record . . . shall include: (8) Time taken and staff initials. Based on record review and interview the facility failed to have complete or accurate Medication Administration Records for 7 of 7 residents'	A36	A 36 A new 2009 Nursing Drug Handbook has been purchased. The facility nurse will make sure this handbook is updated on a yearly basis. The Nursing Drug Handbook is kept in the med room where Med Techs can have access to look up any new medications prescribed for residents and possible side effects. Med Techs will also be in serviced on this handbook	11/10/08 2/10/09

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A36	Continued From page 24 charts reviewed (R2, R3, R5, R9, R21, R23, & R36). The findings are: A) Review on 7/3/08 of resident R9's April, May, and June 2008 Medication Administration Record (MAR) revealed several blanks where there should be entries for recording given, missed, or refused medication administration. Therefore, the MAR could not be used for an accurate record. B) Review on 7/7/08 of resident R23's and R36's May and June 2008 Medication Administration Records (MAR's) revealed several blanks where there should be entries for recording given, missed, or refused medication administration. Therefore, the MAR's could not be used for an accurate record. C) Review on 7/15/08 of resident R2's, R3's, R5's and R21's May and June 2008 MAR's revealed several blanks where there should be entries for recording given, missed, or refused medication administration. Therefore, the MAR's could not be used for an accurate record. D) In an interview with the administrator on 7/11/08 at 8:30 AM, the administrator acknowledged there are several blanks on the residents' MAR's. Refer to 7.8.2.36 G. Medications removed from the pharmacy container . . . not given immediately. . . Based on observation and interview the facility failed to insure medications removed from the pharmacy container or blister pack were given immediately and documented by the person	A36	A 36 A-D A new system has been put into place so that no blanks will be left in the MAR's. (copy of form attached) Weekly the Administrator reviews the MAR's and dates and signs. Any blanks are noted and responsible Med Tech is counseled. 1st occurrence: written warning. 2nd occurrence: suspension and 3rd occurrence termination. Med Techs have also been in service/re-trained on the consequences of blanks in MAR's and the procedure to follow. Documentation of these trainings are in staff charts and in service log book.	10/8/08 8/8/08 & 10/10/08

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A36	Continued From page 25 assisting for 26 of 39 residents (R1 through R26). The findings are: A) Observation on 7/7/08 at 7:12 AM, staff S56 removed a pre-drawn syringe of insulin from the medication refrigerator and went to resident R3's room and assisted with the medication administration. B) Observation on 7/7/08 at 7:26 AM, staff S56 removed a pre-drawn syringe of insulin from the medication refrigerator and went to resident R2's room and assisted with the medication administration. C) In the first interview with staff S56 on 7/7/08 at 7:24 AM, staff S56 acknowledged the facilities nurse pre-draws a one week supply of insulin into syringes for residents R2 and R3. D) In the first interview with the administrator on 7/7/08 at 2:34 PM, the administrator acknowledged the facility's nurse pre-draws insulin into a one week (7 days) supply of pre-drawn syringes for residents' R2 and R3 and all other insulin dependent residents are injected by nurses from an outside Home Health agency. E) In the second interview with the administrator and staff S56 on 7/14/08 at 10:48 AM, the administrator now stated that resident R3's daughter pre-draws insulin every Sunday into a one week (7 days) supply of pre-drawn syringes for resident R3. F) In an interview with the facility's nurse on 7/16/08 at 2:21 PM, the nurse acknowledged she pre-draws syringes of insulin for a one week supply of injections for resident R2.	A36	A 36 A-H The Facility nurse will conduct an in service/re-training for all Med Techs regarding immediately giving each resident their medication as soon as it is removed from the container or blister pack. They will also only document in the MAR's the time it is given and observe the resident taking the medications. All Med Techs will sign that they understand and will abide by the regulations or face suspension or termination. Those residents currently residing will have the option of: 1. Converting to insulin pins or pill form 2. Contract with Home Health to come to the facility to draw and administer their insulin 3. As a last result, the facility will discharge the resident. Cont.	7/10/08 & 2/10/09 2/16/09

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A36	Continued From page 26 G) Observation of the medication refrigerator on 7/16/08 at 2:38 PM revealed a one week supply of pre-drawn syringes for resident R3. The syringes were pre-drawn for a sliding scale as prescribed by the Physician. On the sliding scale resident R3 receives 0, 4, 6, 8, or 10 units of Humalog Slide 4 times a day depending on blood sugar level. Resident R3 also receives 1 injection a day of Humulin N. This equalls 119 syringes to cover a one week period if all possibilities on the sliding scale are allowed for. This represents 119 possibilities for medication errors. H) There was also a one week supply of pre-drawn syringes of insulin marked for resident R2. Resident R2 receives 5 injections a day. That is 35 syringes for a one week supply. I) During tour of the facility on 7/1/08 at 8:01 AM during an already in progress assistance with medication administration, the following was observed: 1. Staff S64 was observed assisting the residents with medication administration in the dining room, 2. The medication cart had 16 pre-poured cups with medications in them, 3. The cups of medications had residents' names on them, 4. Staff S64 would put the cups on the dining room tables by the resident and walk away without observing the resident administer the medications, 5. Staff S64 left the dining room at 8:14 AM with residents R5's, R9's, R14's, and R15's, medications not being taken and still setting on the tables in the cups, and 6. Staff S64 was not observed to document any of the assistance with the medication administration during this time.	A36	A 36 A-H The administrator will begin contacting family members and/or Doctors regarding the changes to take place. Prior to any new admissions, when the Administrator and facility nurse conduct an assessment, the team discussion will include diabetic regulations for those who are diabetic. A 36 1-6 The facility nurse will conduct an in service/re-training for all Med Techs regarding not pre-filling medications of any sort. All Med Techs will sign that they understand and will abide by the regulation. Administrator and facility nurse will Continuously monitor Med Techs. Anyone found to be pre-filling will face disciplinary action.	2/16/09 7/10/08 & 2/10/09

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A36	Continued From page 27 J) In an interview with staff S64 on 7/1/08 at 10:34 AM, staff S64 acknowledged pre-pouring the medications for the 26 residents who are assisted with medication administration. Staff S64 further acknowledged the medications are documented when pre-poured and not during the actual administration of the medications.	A36		
A45	7 NMAC 8.2.45 Heating, Ventilation & Air-Conditioning 7.8.2.45 HEATING, VENTILATION AND AIR-CONDITIONING: A. Heating, air-conditioning, piping, boilers, and ventilation equipment must be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities must have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. B. The heating method used by the facility must provide a minimum temperature of seventy (70) degrees Fahrenheit in all rooms used by the residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device may be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances must be permanently anchored and kept away from flammables such as curtains, bedcoverings, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or danger from electrical shock. D. Fireplaces and open flame heating are not permitted to be utilized in sleeping rooms. E. Gas fired water heaters must not be located in sleeping rooms, bathrooms, or rooms	A45	A 45 A-D A staff review of the regulations regarding ventilation without any screening has been conducted so that all staff understand this regulation. All have signed that they have read and understand. It will be posted in the in service log book. Staff and Administrator will close all doors and windows that do not have a screen in place	1/23/09

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A45	Continued From page 28 opening into sleeping rooms. F. A facility must be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means. G. All openings to the outside air used for ventilation must be screened for the control of insects and rodents. Screen doors must be equipped with self-closing devices. H. A facility must be provided with a system for maintaining residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard or danger from electrical shock. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7-1-64, 9-15-70 9-24-76, 7-11-86, 4-7-97;7.8.2.45 NMAC - Rn, 7 NMAC 8.2.45, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer 7.8.2.45 G. Openings to outside air used for ventilation must be screened. Based on observation and interview the facility used exits for ventilation without any screening for the control of insects and rodents. The findings are: A) During tour of the facility on 7/1/08 at 7:50 AM and again at 8:45 AM, the front center exit to the facility was blocked open for ventilation and the exit was not equipped with a screen. B) During tour of the facility on 7/1/08 at 8:54 AM, at 10:21 AM, and on 7/2/08 at 10:27 AM, an exit from a Northern located living area was blocked open for ventilation and the exit was not equipped with a screen.	A45		

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A45	Continued From page 29 C) During tour of the facility on 7/2/08 at 10:42 AM, an exit from a Northern located hallway area was blocked open for ventilation and the exit was not equipped with a screen. D) In an interview with staff S68 on 7/16/08 at 2:44 PM, staff S68 acknowledged it is common practice at the facility to block exit doors open.	A45		
A66	7 NMAC 8.2.66 Related Regulations & Codes 7.8.2.66 RELATED REGULATIONS AND CODES: Adult residential care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96). B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96). C. Adjudicatory Hearings, New Mexico Department of Health, 7 NMAC 1.2 (2-1-96). [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.66 NMAC - Rn, 7 NMAC 8.2.66, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.66 RELATED REGULATIONS AND CODES This is a repeat deficiency from survey dated 12/27/06. 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: A. General: The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers and hospital caregivers. All applicants for employment	A66		

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A66	Continued From page 30 to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978 (Amended) of the act, a care provider ' s failure to comply is grounds for the state agency having enforcement authority with respect to the care provider to impose appropriate administrative sanctions and penalties. Based on record review and interview the facility failed to have documentation of fees and pertinent application information being sent to the Caregiver Criminal History Screening (CCHS) program for 1 of 4 employees (S72). The findings are: Record review on 7/14/08 revealed no documentation of fees and pertinent application information being sent to the CCHS program for staff S72 with a hire date of 6/22/08. In an interview with the administrator on 7/14/08 at 3:00 PM, the administrator acknowledged fees and pertinent application information had not been sent to the CCHS program for staff S72 This is a repeat deficiency from survey dated 12/27/06. Refer to NMAC 7.1.12 Employee Abuse Registry	A66	A 66 If employee (S72) was the staff member that transferred within the company from another Assisted Living, Administrator will now ensure that any employee transfers will be re-fingerprinted and EAR redone within 5 days of transfer. Documentation of such will then be forwarded to the Corp. Office for payment and timely submission to the proper state authorities.	2/16/09

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A66	Continued From page 31 (Effective January 1, 2006) 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. Based on record review and interview, the facility failed to maintain documentation that the Employee Abuse Registry (EAR) database was checked prior to offer of employment for 3 of 4 staff hired after the effective date of this ruling (S59, S264, & S72). The findings are: A) Record review on 7/14/08 revealed the following: 1. Staff S59 was hired on 1/18/08 and inquiry to the registry was not done until 2/19/08, 2. Staff S64 was hired on 1/26/08 and inquiry to the registry was not done until 2/19/08, 3. Staff S72 was hired on 6/22/08 and no inquiry	A66	A 66 A Administrator will ensure any potential new hires will first be cleared through the EAR prior to application approval. When submitting the application to Corp. Office for approval, a copy of the EAR clearance will be attached. Corp. Office will verify potential new hire has been cleared through EAR.	1/26/09

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A66	Continued From page 32 was made to the registry. B) In an interview with the administrator on 7/14/08 at 3:00 PM, the administrator acknowledged inquiry to the registry had not been done prior to date of hire for staff S59, S64, and S72.	A66		