Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2160	A. BUILDING _____ B. WING _____	04/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIGHT N GAIL ASSISTANT LIVING	7621 PROSPECT AVENUE ALBUQUERQUE, NM 87110

(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
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 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.	A13 ES Scanned 04-21-10 7.8.2.13	The following response and plan of correction in no way constitutes admission that Night N Gail Homecare believes were deficient practices but will respond appropriately to the cited deficiencies per requirements for adult Residential Care facilities 7.8.2. NMAC 12C. ① An application form to increase bed capacity from 3-three to 8- eight has been submitted to DHI (Department of Health Improvement) for approval. All requirements will be met as requested ② Pending approval of the application the current 7 (Seven) residents will continue to reside and receive services at Night N Gail Home Care. This deficient practice will be in compliance by May 1 2010 or upon receipt and accepting	

Division of Health Improvement

Kathleen Gallegos — Owner/Manager — 4/16/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

RECEIVED APR 2010 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

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A13	Continued From page 1 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. (7) Based on observation, record review and interview the facility failed to adhere to the license capacity. The findings are: A. On 03/29/10 during the initial tour of the facility, it was observed that the current census is eight (8) residents in the facility and the temporary license # NM2160 capacity is for three (3). 1. During review of the residents records, eight (8) records were reviewed, and noted. B. During interview on 03/29/10 at 1:30 PM, with the administrator, she confirmed that the facility is operating with total of eight (8) residents in the facility.	A13	of application from DHI.	
A17	7 NMAC 8.2.17 Personnel 7.8.2.17 PERSONNEL: The adult residential care facility must have and implement written personnel policies. The personnel policies must address the following: A. Qualifications for all professional and	A17		

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A17	Continued From page 2 non-professional disciplines. B. Staff conduct which must foster resident safety and well-being and must not be detrimental to resident care. C. Staff training, appropriate to staff responsibilities, including, at a minimum, an orientation and an on-going, but at least annual, program which includes: Fire Safety, First Aid, Safe Food Handling practices, Confidentiality of Records and Resident information, Infection Control, Resident Rights, Reporting Requirements for Abuse, Neglect, and Exploitation, Transportation Safety for Assisting residents and operating vehicles to transport residents and Providing Quality Resident Care based on current resident needs. D. Employee personnel records, including an application for employment, TB tests and certificates, training records, and personnel actions. [4-7-97; 7.8.2.17 NMAC - Rn & A, 7 NMAC 8.2.17, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.17 C. Based on record review and interview the facility failed to implement written personnel policies to address the following staff training for S1 and S2. The findings are: A. During record review on 03/29/10, no documentation of the following staff training was seen or provided : Staff training appropriate to	A17	7.8.2.17.C ① All facility staff will be trained and supporting documentation will be available in the employee file indicating that training has occurred in the following required areas. Fire Safety - First Aid, - Safe food handling practices. - Confidentiality of records and resident information, - Infection Control, - Resident Rights, - Providing Quality resident care based on current resident need, - and reporting requirements for abuse, neglect and exploitation. ② Employees (S1 and S2) will be trained in required	

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A17	Continued From page 3 staff responsibilities including at a minimum, an orientation and an ongoing, but at least annual, program which includes: fire safety, first aid,safe food handling practices, confidentiality of records and resident information, infection control, residents rights, reporting requirements for abuse,neglect, and exploitation, providing quality resident care based on current resident needs. B. During interview on 03/29/10 at 6:30 PM with the administrator, she acknowledged that no training for S1 or S2 had been done.	A17	areas. All new hires will be trained in the required areas within 2 weeks of hire and annually thereafter ③ The facility manager will check each employee file monthly to monitor progress. ④ All staff training will be in compliance with this requirement by May 1, 2010	
A19	7 NMAC 8.2.19 Admissions 7.8.2.19 ADMISSIONS: No resident shall be admitted or retained who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. EXCEPTION: Maternity Shelters may accept residents below the age of eighteen (18). A. ADMISSION INTERVIEW. The Director of the facility or a designee responsible for admission and retention decisions, shall meet with the resident or the resident's agent or guardian, if the resident lacks decision-making capacity, and shall provide the resident with: (1) The facility's program narrative. (2) The facility's rules. (3) The facility's admission agreement, including costs and charges, refund provision, and contract termination policies. (4) The facility's bed hold policy. (5) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (6) A written description of the legal rights of the residents translated into another language, if necessary.	A19		

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A19	Continued From page 4 (7) The facility's staffing pattern. B. RESTRICTIONS ON ADMISSIONS: Adult residential care facilities shall not admit or retain individuals requiring continuous nursing care. Conditions or circumstances that usually require continuous nursing care, may include, but not limited to the following: (1) Ventilator dependency. (2) Pressure sores where skin loss penetrates beyond the skin, and into deeper tissue or bone, which are classified as Stage III or IV. (3) Intravenous therapy or injections directly into the vein. (4) Airborne infectious disease, in a communicable state, including tuberculosis, but excluding infections such as the common cold. (5) Any condition requiring either physical or chemical restraints. (6) Nasogastric tubes / gastric tubes. (7) Tracheostomy care. (8) Individuals presenting an imminent physical threat or danger to self or others. (9) Individuals whose physician certifies that placement is no longer appropriate. C. ADMISSION/RETENTION EXCEPTIONS: If a resident requires a greater degree of care than the facility would normally provide, or is permitted to provide, and the resident wishes to be re-admitted or to remain in the facility, and the facility wishes to re-admit or retain the resident, the facility must: (1) Convene a team, comprised of: (a) The facility director. (b) The resident. (c) The resident's agent, guardian or surrogate decision maker. (d) The resident's advocate, such as the resident's case manager, Ombudsman, or social worker.	A19	7.8.2.19 C (1) A team meeting for R1, consisting of the facility manager, professional nurse and 2 staff from the Hospice agency, was held on 4/2/10. It was determined that the facility was unable to meet this resident's needs and R1 was transferred to another health facility.	

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A19	Continued From page 5 (e) If the treating physician is unable to meet with the team, then consultation and recommendations via phone is acceptable. (f) Other appropriate health care professionals. (2) The team shall jointly determine if the resident should be admitted or allowed to remain in the facility. The team must approve a individual service plan that meets the specific needs of the resident. Such team approval must be in writing, signed and dated by all team members, must be maintained in the resident's record, and must: (a) Be based upon a individual service plan which identifies the resident's specific needs and addresses the manner that such needs will be met. (b) Ensure that the facility has and will maintain an evacuation rating of prompt or slow as determined by the Fire Safety Equivalency System (FSES). (c) Be based upon an assessment of the health, safety and well-being of the other facility residents. (d) Assess the impact that meeting the specific needs of the resident as set out in the individual service plan will have on the staff and on the other residents. (3) Notify the Licensing Authority within five (5) days of the completion of team approval. Such notification of team approval must be submitted in writing and include evidence of the team's consideration of items 7.8.2.19C2(a) through 7.8.2.19C2(d) above. [9-24-76, 7-11-86, 1-11-90, 4-7-97;7.8.2.19 NMAC - Rn. 7 NMAC 8.2.19, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.19 (C) (1)	A19	R4 and R5 are no longer on Hospice and continue to reside at the facility. (2) All future residents who require a greater degree of care than the facility normally provides will be evaluated via a team meeting to determine if facility staff can provide for their individual needs. The list of Services and goals will be outlined in the individual service plan and all components of 7.8.2.19C(1) will be met. (3) The facility manager will monitor all residents on a daily basis and alert the appropriate agency responsible party and facility team if there is a significant change in a residents condition. (4) This deficient practice is now in compliance.	

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A19	Continued From page 6 Based on record review and interview, the facility failed to convene a team meeting for 3 of 8 residents who requires nursing services. Resident R1, R4 and R5. The findings are: A. During review of the resident records on 03/29/10, at 2:25 PM, there was no documentation that a hospice team meeting was held for R1, R4,and R5.these three residents are currently receiving the services from a hospice nursing agency. B. During an interview on 03/29/10 at 2:25 PM with the administrator, she acknowledged that there was no team meeting convened for R1, R4 and R5.	A19		
A22	7 NMAC 8.2.22 Resident Records 7.8.2.22 RESIDENT RECORDS: A. RESIDENT RECORDS, CONTENTS: A record for each resident shall be maintained with specific information required. Entries in each resident's record shall be legible, dated, and authenticated by the signature of the person making the entry. Resident records must include: (1) Admission records as set out in Section 7.8.2.21 NMAC: (2) Within five (5) days of admission: (a) An executed admission agreement. (b) A completed resident assessment form. (c) Any available, admission physical examination report by a licensed health care professional, which may include all discharge information from another facility. When admission follows within thirty (30) days discharge from an acute care hospital, the hospital history and	A22 7.8.2.22	A. The unavailable physical examinations, photographs, resident's assessment service plans, entries by direct care staff, medication administration records, written consent by resident or guardian to assist with medications, storing records in a organized accessible and permanent manner have been corrected as evidenced by the following @ A physical exam for R4 + R5 was completed on March 4 2010 The physical exam for R1 was completed on April 5 2010.	

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A22	Continued From page 7 physical report, and the hospital discharge summary may serve as an admission physical. (d) Names, addresses, relationship, and phone numbers of family members, and where appropriate, guardians, agents, and any surrogate decision makers. (3) Within thirty (30) days of admission: (a) A admission physical examination report by a licensed health care professional if an examination report was not available within five (5) days of admission. (b) Resident's name, age, recent photograph, social security number, marital status, date of birth, sex, address prior to admission, religion (optional), personal physician, dentist, social history and designated representative or other emergency contact person, language spoken and understood, legal documentation relevant to commitment and/or guardianship status, present medications, and diet required. (c) Any amendments to the admission agreement. (d) The current completed resident assessment form. (e) A completed and current individual service plan. (f) Entries by direct care staff, appropriate health care professionals, or others authorized to care for the resident. Entries shall be dated and signed by the person making the entry and shall include significant information related to the individual service plan. (g) Entries providing a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention, and entries reflecting appropriate follow-up. The	A22	The results of the exam are in their medical records. All new admits will have their physical exam completed in 5-30 days of admission. (b) Photographs of R # 1 & 2 are now displayed in their respective rooms. Photographs of the remaining residents have been taken and are in the medical records. New admits will have their photographs taken upon admission. (c) Individual Resident Assessments were completed for the eight (8) identified residents on April 15, 2010. All new admits will have their resident assessment completed within 5 days of admission. (d) Service plans for the eight identified residents are now completed and signed by a licensed nurse. All new admits will have their service plans completed within 14 days of admission. (e) Entries by direct care staff into the residents medical records commenced on April 1, 2010. New admits will have entries noted	

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A22	Continued From page 8 maintenance of such written record in the resident record may be by copy of an incident/accident report, if the original incident/accident report is maintained elsewhere by the facility. (h) A medication record: Medications administered by licensed personnel and/or staff assisting with medications to include: listing all currently ordered medications by name, dosage, administration times; documenting by medication name, dosage, date, and time, each medication administered, with the initials of the individual who administered or assisted with the medication; documentation of errors, omissions, and side-effects of medications; and written consent by resident or guardian for staff to assisting with medications. (i) Date, time and progress note of health services provided by any contract agency. (j) Unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures. (k) Transfer forms completed, signed, and provided to accepting facility when resident is transferring to a hospital or another health care facility. (l) Documentation of disposition of the resident's personal effects and money or valuables deposited with the adult residential care facility, upon death or transfer. B. RESIDENT RECORDS, MAINTENANCE: (1) Resident records shall be maintained and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy for maintaining, and confidentiality of resident records, including the authorized release of	A22	by direct care staff on admission and on going. (1) MARs (Medication administration record) are now available for the current seven (7) residents. The MAR will include all requirements of 7.8.2.36 F1-10. (2) Written consent by resident or guardian for staff to assist with medications are now available in the resident records of R2 and R8. This form is also available in the medical records of the current residents. (3) Resident records (7) are now organized, maintained and stored in an accessible and permanent manner. (4) The medical records for the (7) current residents will be audited and all required documentation that is noted in 7.8.2.24 A (2) b) (c), (3) b) (b)(d)(e)(f)(g)(h) and B(i) will be available as required (5) The facility manager will do a complete chart audit on all resident medical records weekly for 4 weeks and monthly ~~thereafter~~ thereafter for compliance. (6) This deficiency practice will be in compliance by May 1, 2010	

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A22	Continued From page 9 resident records. (3) Resident records must be maintained by the facility against loss, destruction, and unauthorized use for a period of not less than three (3) years from the date of discharge. (4) There must be a policy and procedure in place for record retention in the event of facility closure. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 7.8.2.22 NMAC - Rn 7 NMAC 8.2.22, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.22 A.(2) (b)(c) (3)(a) (b)(d)(e)(f) (g)(h) B. (1) Based on record review and interview the facility failed to include all required documents in the resident record for eight (8) of 8 residents (R1,R2,R3,R4,R5,R6,R7and R8). The findings are: A. The record review on 03/29/10, for three (3) of 8 residents, R4, R5and R7 revealed that the admission records were incomplete, there were no dates, or signatures for the admission agreements. 1. The record review on 03/29/10, for eight (8) of 8 residents revealed there were no admission physical examinations done by a licensed health care professional within five (5) days of admission or within 30 days of admission. 2.The record review on 03/29/10, for two (2) of 8 residents, R2 and R3 revealed there were no recent photographs.	A22		

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A22	Continued From page 10 3. The record review on 03/29/10, for eight (8) of 8 residents revealed there were no resident assessments done. 4. The record review on 03/29/10, for eight (8) of 8 residents revealed there were no individual service plans done within the required 14 day of admission period. 5. The record review on 03/29/10, for eight (8) of 8 residents revealed there were no entries by direct care staff. 6. The record review on 03/29/10, for eight (8) of 8 residents revealed there were no medication administration records. 7. The record review on 03/29/10, for three (3) of 8 residents R1, R2, and R8, revealed there were no written consent by resident or guardian for staff to assist with medications. 8. The record review on 03/29/10, for eight (8) of 8 residents revealed that the residents' record is not maintained and stored in an organized , accessible and permanent manner. B. During interview on 03/29/10 at 2:00 PM with administrator, she stated she was not aware that all this information was needed for the record.	A22		
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	A23	8.2.23 1) The unavailable reports/records ascited are now available for review 2) Environmental health was	

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A23	Continued From page 11 facility must keep the following reports, records, and policy and procedures on file at the facility and make them available for review upon request of the Licensing Authority: (1) Fire Inspection Report. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have fire inspection reports. (2) Copy of the last survey conducted by the Licensing Authority, adverse actions or appeals thereto, and complaints. (3) Copy of the latest survey from Environmental Health Authority (if applicable) regarding kitchen and food management and, if private sewage disposal, and private waste disposal. EXCEPTIONS: Adult residential care facilities with three (3) or fewer residents are not required to be inspected by Environmental Health Authority. Facilities exempted by the Environmental Health Authority having jurisdiction, are not required to have a survey on file provided the exemption letter is on file. (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	A23	notified on 4/11/2010 to complete a kitchen and food management inspection. The report will be filed following the inspection (5) One month menus planned and served will be on file for 30 days (6) Records of monthly fire drills held at different times during the day will be on file for review stating the date, time of drill and any problems noted during the drill along with the evacuation time in total minutes (4) All pets housed at the facility and those pets who live off the facility will now have vaccination records available for review (3) Staff training records for all staff will be available for review as stated in 7.8.2.17C (2) All required reports and records will be reviewed by the facility manager monthly for the next 12 months and periodically thereafter	

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	2160	A. BUILDING _____ B. WING _____	04/01/2010

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A23	Continued From page 12 Residential Care Facilities, 7.8.2 NMAC). (9) Custodial Drug Permit: A valid Custodial Drug Permit issued by the State Board of Pharmacy for those facilities licensed pursuant to these regulations. EXCEPTION: Adult residential care facilities with only one (1) resident are not required to have a custodial drug permit. (10) Vaccination of pets in the facility. (11) Staff training. (a) At orientation and on-going. (b) Appropriate to staff responsibilities. (Assistance with medications, dietary, environmental...) (c) Fire safety. (d) First aid. (e) Safe food handling practices. (f) Confidentiality of records and resident information. (g) Infection control (including universal precautions and linen handling). (h) Resident rights. (i) Providing Quality Resident care 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.	A23	(3) This deficient practice will be in compliance May 1, 2010	

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A23	Continued From page 13 (2) The use of the telephone. (3) Operation of television, radio, and stereo. (5) Use and safekeeping of personal property. (6) Meals. (7) Use of common areas. (8) Electric blankets or appliances used by residents. C. POLICIES AND PROCEDURES: All facilities shall have written policies and procedures covering the following areas: (1) Actions to be taken in case of accidents or emergencies, (e.g., gas leaks, injuries, transportation, medications,...). (2) Method of keeping informed when residents go outside of the facility (e.g., sign-out sheets). (3) The handling or resident's funds, if the facility provides such services. (4) Reporting of incidents, including abuse, neglect, and exploitation. (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.	A23		

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A23	Continued From page 14 (17) NOTE FOR MATERNITY SHELTERS ONLY: In addition to the required policy and procedure topics listed above, Maternity Shelters shall have written policies and procedures regarding infant formula, feeding and equipment, and laundering of infant linen and diapers. (18) Staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles. (19) Staff training for employees who operate motor vehicles to transport residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.23 NMAC - Rn & A 7 NMAC 8.2.23, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.23 A.(3)(5)(6) (10)(11) Based on records review and interview, the facility failed to have on file, all required records/reports. The findings are: A. During review of the facility records on 03/29/10, no record of an environmental health authority survey was available 1. During review of reports, it was noted that there was no record of monthly fire drills, or staff training of fire safety. 2. During review of reports, it was noted that there was no record of monthly menus planned and served. 3. During record review on 03/29/10, no documentation of the following staff training was seen or provided : Orientation and ongoing, fire safety, first aide,safe food handling practices,	A23		

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A23	Continued From page 15 confidentiality of records and resident information, infection control, residents rights, reporting requirements for abuse,neglect, and exploitation. 4. During record review on 03/29/10, no documentation of pet vaccination was found for the resident's pet residing in the facility B. During interview on 03/29/10 at 1:00 PM with the administrator, she confirmed that the reports were not available.	A23		
A24	7 NMAC 8.2.24 Pets 7.8.2.24 PETS: Pets are permitted in a licensed facility, in accordance with the facility's rules. A. Pets are not permitted in the kitchen or food preparation areas. B. Pets shall be vaccinated in accordance with all state and local requirements and records of such vaccination shall be kept on file in the facility [7-11-86, 4-7-97; 7.8.2.24 NMAC - Rn, 7 NMAC 8.2.24, 8-31-00] This REQUIREMENT is not met as evidenced by: Refers to NMAC 7.8.2.24 B. Based on record review and interview, the facility failed to ensure that documentation of vaccination was available for the 1 of 1 resident pet (P#1). The findings are: A. On 03/29/10 at 1:30 PM, during review of the facility records, there was no evidence of vaccination documentation for P#1. B. During interview on 03/29/10 at 1:30 PM with the administrator, she acknowledged there was	A24	7.8.2.24 1) Vaccination records are now available for P#1 2) Future house and visiting pets will have vaccination records available at the time they are brought to the facility. 3) The house manager will review the pet record file monthly to insure that all pets have their vaccinations records available for review. 4) This deficient practice is now in compliance	

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A24	Continued From page 16 no vaccination record for the pet.	A24		
A26	7 NMAC 8.2.26 Resident Assessment 7.8.2.26 RESIDENT ASSESSMENT: A. A resident assessment to determine level of function and if the client's needs can be met by the facility. The initial assessment must be completed within five (5) days of admission and reviewed every six (6) months as part of the individual service plan. B. The resident assessment must establish a baseline in the resident's functional status and thereafter, identify resident changes through periodic reassessments. C. The resident assessment must be documented on a state approved resident assessment form and at a minimum include the following: (1) Cognitive patterns. (2) Communication/hearing patterns. (3) Vision patterns. (4) Physical functioning and structural problems. (5) Continence. (6) Psycho social well-being. (7) Mood and behavior patterns. (8) Activity pursuit patterns. (9) Disease diagnoses. (10) Health conditions. (11) Oral/nutritional status. (12) Oral/dental status. (13) Skin conditions. (14) Medication use. (15) Special treatment and procedures. D. The resident admission assessment, the physical exam report, and the observation and evaluation of staff with regards to the needs will be used to develop the individual service plan, if needed. If the resident assessment does not	A26 7.8.2.26	A, B, C, D. 1) Individual resident assessments for R2, R3, R4, R5, R6, R7, R8. were completed on April 15th 2010 2) New admits to the facility will have their individual resident assesment completed within 5 days of admission 3) The facility manager will do a chart audit on each new resident with 5 days of their admission for completion of the resident assessment. A chart audit will be completed weekly for 4 weeks and then monthly thereafter 4) This deficient practice will be in compliance by May 1 2010	

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A26	Continued From page 17 indicate a need for an individual service plan, then an individual service plan is not required. However, an individual service plan must be prepared for residents requiring nursing services. [4-7-97; 7.8.2.26 NMAC - Rn, 7 NMAC 8.2.26, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.26 A. B. C D. Based on record review and interview the facility failed to complete the resident assessment documents for eight (8) of 8 residents, R1,R2,R3,R4,R5,R6,R7, andR8. The findings are: A. During record review on 03/29/10, it was noted that 8 of 8 residents, (R1,R2,R3,R4,R5,R6,R7, and R8), did not have a completed, current resident assessment with in the required 5 days of admission. 1. Admission dates: R1- 02/17/09 R2- 03/22/10 R3- 03/22/10 R4- 10/09/09 R5- 12/08/09 R6- 11/15/09 R7- 04/02/09 R8- 05/21/09 B. During interview on 03/29/10 at 2:00 PM with the administrator, she acknowledged that the resident assessments were not done.	A26		
A27	7 NMAC 8.2.27 Individual Services Plan 7.8.2.27 INDIVIDUAL SERVICE PLAN: A. An individual service plan, if prompted by the resident assessment, shall be developed and	A27	7.8.2.27 A.B. Individual service plans for the following residents R2, R3, R4, R5, R6, R7, R8	

Division of Health Improvement

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A27	Continued From page 18 implemented within fourteen (14) days of admission, and must address those areas of need as identified in the resident assessment. The individual service plan must be reviewed by a licensed nurse at least every six (6) months, and revised as needed at the time of each assessment and consistently implemented in response to the resident's needs. B. The individual service plan must include the following: (1) Description of identified needs as noted in the resident assessment. (2) Written description of what services will be provided. (3) Who will provide the services. (4) When or how often the services will be provided. (5) How the services will be provided. (6) Where the services will be provided. (7) Goal and outcome of the service. (8) Documentation of the facility's determination that it is able to meet the needs of the resident.. [7-11-86, 1-11-90, 4-7-97; 7.8.2.27 NMAC - Rn, 7 NMAC.8.2.27, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2. 27 A. B. Based on record review and interview, the facility failed to ensue that individual service plans were completed for eight (8) of residents, (R1, R2, R3, R4, R5, R6, R7 and R8) with in the 14 days of admission. The findings are: A. During record review on 03/29/10, it was noted that 8 of 8 residents did not have an individual service plan within the rquired 14 days of admission.	A27	have been completed, signed and dated by a licensed nurse. All new admits will have their service plan completed, signed and dated by a professional Nurse within 14 days of admission if prompted by the resident assesment. All current residents will have their service plan updated in 6 months or sooner if there is a significant change in their condition. Hospice ~~and~~ resident service plans will be correlated with the Hospice agency staff. 3) The facility manager will do a chart review daily on all residents, including Hospice residents for change in condition. Service plans will be updated by a licensed Professional Nurse as Needed. 4) This deficiency will be in compliance by May 1, 2010	

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A27	Continued From page 19 1. Admission dates: R1- 02/17/09 R2- 03/22/10 R3- 03/22/10 R4- 10/09/09 R5- 12/08/09 R6- 11/15/09 R7- 04/02/09 R8- 05/21/09 B. During interview on 03/29/10 at 2:45 PM with the administrator, she acknowledged that the individual service plans were not done for 8 of 8 residents.	A27		
A36	7 NMAC 8.2.36 Medications 7.8.2.36 MEDICATIONS: Medications will be administered or staff assistance with medications provided and documented in accordance with state and federal laws. A. Licensed health care professionals are responsible for the administration of medications. B. Facility staff may assist a resident with medications if written consent by the resident is given to the director of the facility or their designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with 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	A36	7.8.2.36 F 1) A written consent form noting that staff may assist with administration of medications, was signed and dated on April 15 2010 for residents R6 + R8 2) R2, R3, R4, R5, R7, now have a written consent for staff to assist with medications signed and dated by either themselves or their responsible party. All new admissions will sign and date a facility assistance with medication form upon admission. 3) The facility manager will do a chart audit on all new admissions and note if the assistance with med form has been signed + dated. 4) This deficient practice will be in compliance by May 1, 2010	

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A36	Continued From page 20 resident's record. D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and side-effects. E. Medications prescribed for one resident shall not be used for another resident. F. The facility shall have a Medication Administration Record (MAR) documenting medications administered to residents, including over-the-counter medications. This documentation shall include: (1) Name of resident. (2) Date started. (3) Drug product name. (4) Dosage and form. (5) Strength of drug. (6) Route of administration (e.g. "by mouth"). (7) How often medication is to be taken. (8) Time taken and staff initials. (9) Dates when the medication is discontinued or changed. (10) The name and initials of all staff administering medications. G. Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting. H. PRN Medications: The use of PRN medications must be closely monitored and 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:	A36	(1) Two (2) of two (2) staff members who assist residents with their medication will take the medications training program on _____ (2) All new hires will be required to take the med training program within 2 weeks from date of hire and will not assist with medications until training has been completed. (3) The facility manager will be responsible to see that all new staff will receive med training per facility policy and 7.8.2.36 regulation. Employee file will be audited monthly for completion. (4) This deficient practice will be in compliance May 1, 2010 (5) The facility Pharmacy	

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A36	Continued From page 21 (a) Symptoms that might indicate the use of the medication. (b) Exact dosage to be used. (c) The exact amount of medication to be used in a 24 hour period. (d) Directions as to what to do if the symptoms persist. (e) Possible interactions or side-effects that might occur. (f) Manufacturer's label information for directions if deemed adequate by the physician. I. The facility must report all medication errors to the physician. J. The facility shall develop and follow a written policy for unused, outdated, or recalled medications being kept in the facility. [7-1-64, 9-15-70, 7019074, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.36 NMAC - Rn, 7 NMAC 8.2.36, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.36 B. F. Based on record review and interview the facility failed to ensure that a written consent for staff to assist with administration of medications was signed and dated by resident or guardian for 3 of 8 residents (, R1,R6 and R8). A. During record review on 03/29/10 at 3:00 PM, there was no written consent for staff to assist with administration of medications for R1, R6, and R8. B. During an interview on 03/29/10 3:00 PM, with the administrator, she acknowledged there was no written consent for staff to assist with administration of medications for R1, R6 and R8.	A36	has been contacted and will provide a MAR (Medication administration record) for each current resident. The MAR will contain all the requirements of 7.8.2.36 F (1) through (10) (2) The monthly updated MAR will be available to the facility at the beginning of each month and all new admits will have a current MAR available within one day of admission with all requirements noted I am required to check with my pharmacist if this is realistic (3) The facility manager will review the current MARS of each resident daily and will be responsible in reviewing for completion and accuracy at the end of the month The completed MAR will be filed in the residents medical record.	

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A36	Continued From page 22 Based on record review and interview the facility failed to ensure that staff assisting with medications had successfully completed an approved assistance with medications training program for two (2) of 2 staff. The findings are: A. During review of staff training records on 03/29/10, it was noted that 2 of 2 staff had not completed the approved assistance with medications training program. B. During interview on 03/29/10 at 3:15 PM with the administrator, she confirmed that the staff had not completed the approved assistance with medications training program. Based on record review and interview the facility failed to ensure that a Medication Administration Record (MAR) documenting medication administered to eight (8) of 8 residents was available. The findings are: A. During review of medication administration record (MAR) on 03/29/10 it was noted that a MAR was not available or provided. B. During interview on 03/20/10 at 3:15 PM with administrator, she confirmed there was no medication administration record available.	A36	(4) This deficient practice will be in compliance by May 1, 2010	
A37	7 NMAC 8.2.37 Nutrition 7.8.2.37 NUTRITION: Each facility shall provide planned and nutritionally balanced meals in accordance with the recommended daily dietary allowance from the basic food groups to	A37 7.8.2.37	Menus. 1. Menus as served commenced on April 4, 2010. All menus as served will be kept for	

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A37	Continued From page 23 meet the nutritional needs of the age group. A. At least three (3) meals shall be served daily at regular times, or in accordance with the program narrative. (1) No more than a sixteen (16) hour span may exist between a substantial evening meal and breakfast. Snacks must be made available between meals and in the evening and must be listed on the daily menu. Vending machines shall not be considered a source of snacks. (2) A sufficient amount of time shall be allowed for meals to enable residents to eat at a leisurely pace and to socialize. B. A copy of the current week's menu, including snacks and therapeutic diets, shall be posted where residents and families can see it. Posted menus shall be followed and any substitution must be of equivalent nutritional value and recorded on the posted menu. Menus as served must be kept for thirty (30) days and be available to the public. Identical menus shall not be used on a one (1) week cycle basis. C. Therapeutic diets and prescribed vitamin and mineral supplements shall be given and served only on the written orders of a physician. The physician's order shall become part of the resident's record and shall be updated as necessary. D. The facility shall make every reasonable attempt to accommodate the resident's food preferences, and requests by the resident or the resident's representative to observe religious or cultural dietary practices. E. Personnel handling food must be in good health , practice hygienic food-handling techniques, have good personal grooming, and be free from communicable disease transmissible via food. F. Ensure the food is prepared by methods	A37	30 days. 2. Posted menu's will be followed and any substitutions will be recorded on the daily menu. Identical menus will not be used on a one week cycle. 3. The facility manager will monitor the menu daily and note if a needed substitution has the same nutritional value. The menu with snacks and therapeutic diet will be posted where resident and families can see it 4. This regulation is now in compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2160	A. BUILDING _____ B. WING _____	04/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIGHT N GAIL ASSISTANT LIVING	7621 PROSPECT AVENUE ALBUQUERQUE, NM 87110

(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
A37	Continued From page 24 that will conserve nutritive value, enhance flavor, appearance, and is served at the proper temperature and in a form to meet individual needs. G. All residents must be served in a dining room except for residents with a temporary illness, or documented specific personal preference. H. If a resident consistently refuses to eat after encouragement, the resident shall be evaluated by an appropriate health professional. The resident shall be offered fluids more often during the time he/she is refusing to eat. [7-1-64, 9-15-70, 5-26-72, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97;7.8.2.37 NMAC - Rn, 7 NMAC 8.2.37, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.37 Menus Based on record review and interview, the facility failed to keep menus as planned and served for thirty (30) days. The findings are: A. During record review on 03/29/10 menus were not kept for thirty (30) days. B. During interview on 03/29/10 at 3:45 PM with the administrator, she confirmed that menus were not kept or available to the public.	A37		
A41	7 NMAC 8.2.41 Building Construction 7.8.2.41 BUILDING CONSTRUCTION: When construction of buildings, additions,or alterations to existing buildings are contemplated, plans, code analysis and specifications covering all	A41	7.82.41A (3) Facility Evacuation 1. A facility evacuation rating was completed on 5/15/2010	

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NIGHT N GAIL ASSISTANT LIVING	7621 PROSPECT AVENUE ALBUQUERQUE, NM 87110

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A41	Continued From page 25 portions of the work shall be submitted to the Licensing Authority for plan review and approval prior to beginning actual construction. When an addition or alteration is contemplated, plans for the entire facility must also be submitted. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to submit floor plans. A. Building construction and the fire resistance required shall be based upon the capacity of the facility and the residents ability to evacuate the building, in accordance with the Uniform Building Code and NFPA 101 (Life Safety Code). (1) Larger buildings, which are more difficult to evacuate, require more built-in fire protection than smaller buildings. Occupants who are more difficult to evacuate require more built in fire protection than occupants who are easy to evacuate. (2) Evacuation capability, in accordance with NFPA 101, Fire Safety Equivalency System (FSES), must be determined before proceeding to identify applicable building requirements. Evacuation capability is not determined on the basis of that resident who is least capable to evacuate, but rather for the entire facility. (3) Facilities not capable of prompt evacuation may not house residents unless the building is constructed to provide protection to these residents. All facilities that are rated as impractical to evacuate shall be protected throughout by an automatic fire protection (sprinkler) system. Facilities that are rated impractical to evacuate and that do not comply with the more restrictive building standards may not continue to care for residents. (4) NEWLY LICENSED AND/OR CONSTRUCTED ADULT RESIDENTIAL CARE FACILITIES: Shall be protected throughout by an	A41	for ~~R1~~ R2, R3, R4, R5, R6, R7 R8. 2. A facility evacuation rating will be completed monthly for all residents. when a new resident is admitted an additional facility evacuation rating will be completed and the average noted. A facility evacuation rating will also be conducted following the admission/ retention of a Hospice resident. 3. The facility manager will do daily rounds and observe the condition of each resident to determine if an evacuation rating must be completed. 4. This deficient practice will be in compliance by may. 1, 2010.	

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	2160	A. BUILDING _____ B. WING _____	04/01/2010

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A41	Continued From page 26	A41		

approved, automatic fire protection (sprinkler) system. EXCEPTION 1: Sprinklers shall not be required in facilities serving eight (8) or fewer residents maintaining prompt evacuation capability.

(5) CURRENTLY LICENSED FACILITIES: Any facility currently licensed on the date these regulations are promulgated and which provides the services prescribed under these regulations, but fails to meet all building requirements, may be granted a variance to continue to be licensed provided:

(a) The facility was in compliance with codes and standards at the time of initial licensure.

(b) Variances granted will not create a hazard to the health, safety, or welfare of residents and staff.

(c) The facility maintains prompt evacuation capabilities.

B. Minimum construction requirements shall be a twenty (20) minute fire resistance rating for all bearing walls and partitions, floor construction, roofs, columns, beams, girders and trusses.

C. NUMBER OF STORIES: Facilities may be of any number of stories if they comply with Uniform Building Code and NFPA 101 (Life Safety Code), with respect to construction and ability of the residents to evacuate in a timely manner.

(1) One story buildings may be of Type V-(000) construction if all residents are capable of prompt evacuation.

(2) Two story buildings must be of at least one hour construction. Residents who are not capable of prompt evacuation may not be housed above the street-level unless the facility is protected by an approved automatic fire protection (sprinkler) system.

(3) Three stories or more require the

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A41	Continued From page 27 building to be protected by an approved automatic fire protection (sprinkler) system. D. ACCESS TO PERSONS WITH DISABILITIES: Consultation may be given to new facilities on access requirements upon submission of floor plans during the initial licensing process. With the exception of Adult Residential Care Facilities with three or fewer residents, accessibility to persons with disabilities must be provided in all facilities in accordance with New Mexico Building Code and the American Disabilities Act and shall, as a minimum, include the following: (1) Main entry into the facility must provide wheelchair access. (2) Building must allow access to main living area and dining area. (3) At least one bedroom shall be provided a door clearance of thirty-four (34) inches (thirty six (36) inches is recommended) for wheelchair access. (4) One toilet and bathing facility is required a minimum door clearance of thirty-four (34) inches (thirty six (36) inches is recommended) for wheelchair access. This toilet and bathing area must provide a sixty (60) inch diameter clear space (turning radius for a wheelchair). (5) If ramps are provided to the building, a minimum slope of twelve (12)inches horizontal run for each one (1) inch of vertical rise is required. Ramps exceeding a six (6) inch rise shall be provided with handrails. (6) Landings at doorways must have a minimum five (5) foot by five (5) foot level area at the doorway to provide clear space for wheelchair maneuvering. E. PROHIBITION ON MOBILE HOMES: Trailers and mobile homes shall not be used for any part of any adult residential care facility	A41		

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A41	Continued From page 28 caring for more than three (3) residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.41 NMAC - Rn, 7 NMAC 8.2.41, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.41 A.(3) Based on record review and interview the facility failed to complete and maintain facility evacuation ratings to ensure prompt or slow evacuation capability for eight (8) of 8 residents (R1,R2,R3,R4,R5,R6,R7,and R8). The findings are: A. During record review on 03/29/10, there was no documentation of the facility evacuation rating for 8 of 8 residents,(R1,R2,R3,R4,R5,R6,R7 and R8). B. During interview on 03/29/10 at 4: 30 PM with the administrator, she confirmed no evacuations were done for 8 of 8 residents.	A41		
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	A45 7.8.2.45G	Ventilation 1. The five (5) windows cited now have screens added. 2. The facility Manager will monitor the	

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A45	Continued From page 29 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 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 to 7.8.2. 45 G.	A45	windows with screens for holes etc. All tears, holes etc will be promptly repaired to provide for safety and proper ventilation 3. This deficient practice is now in compliance.	

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A45	Continued From page 30 Based on observation and interview the facility failed to insure windows for ventilation are screened for the control of insects and rodents for 5 windows. The findings are: A. During tour of the facility on 03/29/10, it was observed that there were no screens on 5 windows. B. During interview on 03/29/10 at 4:00 PM with the administrator, she acknowledged that the 5 windows did not have screens on them.	A45		
A63	7 NMAC 8.2.63 Staff & Resident Fire & SafetyTraining 7.8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff personnel of the facility must know the location of and be instructed in proper use of fire extinguishers and other procedures to be observed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff must be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways, and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident must upon being accepted into the facility be given an orientation tour of the facility to include, but not be limited to, the location of the exits, fire extinguishers, and	A63 7.8.2.63 D	(1-5) Monthly fire drills 1. A fire alarm system will be installed on 5/1/2010. A fire drill will be conducted following the installation of the alarm system. A fire drill form will be completed noting the date, time of drill, how many residents	

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A63	Continued From page 31 telephones, and shall be instructed in action to be taken in case of fire or other emergency. D. Fire Drills: The facility must conduct at least one (1) fire drill each month: (1) Fire drills must be held at different times of the day. (2) The fire alarm system or detector system in the facility shall be used in the conduct of fire drills. (3) In the conduct of fire drills, emphasis must be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of fire drills held must be maintained on file in the facility. Such record must show date and time of the drill, number of personnel participating in the drill, any problem noted during the drill and the evacuation time in total minutes. (5) The local fire department should be requested to supervise and participate in fire drills. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.63 NMAC - Rn, 7 NMAC 8.2.63, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.63 D.(1-5) Based on record review and interview, the facility failed to conduct fire drills on a monthly basis. The findings are: A. Record review on 03/29/10 revealed no documentation of monthly fire drills conducted. B. In an interview with the administrator on 03/29/10 at 5:30 PM, she acknowledged that the fire drills had not been done.	A63	participated etc. 2. A monthly fire drill will be conducted at least once a month and on different times of the day The fire alam system will be used to conduct the drill. The results of the monthly drill will be available for review and copies of the ~~drill~~ results will be filed. The fire department will be requested to supervise and participate in a fire drill annually. All staff will be instructed in the fire Safty 3. This defficient practice will be in compliance by May 1, 2010 or following the Installation of the	

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A66	Continued From page 32	A66	Alarm System.	
A66	7 NMAC 8.2.66 Related Regulations & Codes	A66		
	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]	7.8.2.66	Related Regulations and codes. 1. Incident Management training. a. Incident Management Training (IMT) will be completed for staff S1 and S2 on 5/1/2010 b. All new hires will receive incident management training within 30 days of hire and annually. c. This deficient practice will be in compliance by May 1, 2010.	
	This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.66 Related Regulations and Codes Refer to NMAC 7.1.13.10(D) Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Requirement to maintain documentation of Incident Management Training for all employees Based on record review and interview, the facility failed to ensure required documentation of annual training on Incident Management Reporting process for 2 of 2 sampled staff (S1and S2). The findings are: A. On 03/29/10 during review of the employee files, it was noted the following required -Incident Management training documentation was not among administrative paperwork for S1 and S2.		2. CC HS documentation a. CCHS CNM Caregivers Criminal History Screening	

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A66	Continued From page 33 B. During interview on 03/29/10 at 5:45 PM with the administrator, she acknowledged the training was not done for S1 and S2. Based on record review and interview the facility failed to have on site documentation that direct care staff had been cleared through the New Mexico Care Givers' Criminal History Screening (CCHS) Program(NMAC 7.1.9) for 1 of 2 employees (S1,) The findings are: A. During record review, on 03/29/10 no documentation of a clearance letter from the New Mexico Caregivers' Criminal History Screening Program (CCHS) was seen for(S1,) with a hire date of 12/01/09. B. During an interview on 03/29/10 at 5:45 PM, with the administrator, she acknowledged that there was no documentation to be found for S1. Based on record review and interview the facility failed to maintain documentation that the Employee Abuse Registry (EAR) was checked in accordance with NMAC 7.1.12 (effective January 1, 2006) for 1 of 2 employees (S1). The findings are: A. During review of the employee files it was noted that an employee hired 12/01/09 (S1), did not have on file documentation of a search of the registry using the individual's identifying information. B. During an interview on 03/29/10 at 5:45 PM with the administrator, she acknowledged there was no search done for S1.	A66	Program) was initiated on April 14, 2010 for employee S1. A receipt is on file to verify Application. Facility manager will monitor personnel file for results of Screening. All new hires will have their CCHC completed within 20 Calendar days from date of hire. A receipt will be on file to note application this difficient practice is now in Compliance. 3. EAR (Employee Abuse Registry) The (Employee abuse registry) was Searched on 4/16/2010 S1 results	

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			All potential new hires will have EAR Searched before employment and findings will be noted. This deficient practice will be in compliance by May 1, 2010	