STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BUILDING _____ B. WING _____	09/30/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF LOS LUNAS	1650 LOS LENTES RD NE LOS LUNAS, NM 87031

(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
A18	7 NMAC 8.2.18 Staffing The following staffing levels are minimums only. The facility shall employ staff capable and trained to provide the basic care and resident assistance and supervision required, based on the assessment of the residents needs. A. When residents are awake, all facilities shall have at least one (1) direct care staff person on duty and awake for each fifteen (15) residents. (1) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty and responsible for the care and supervision when residents are in the facility. (2) During resident sleeping hours, facilities with sixteen (16) to sixty (60) residents shall have at least one (1) direct care staff person awake at all times and at least one (1) additional staff person available on the premises. (3) During resident sleeping hours, facilities with sixty-one (61) to one-hundred twenty (120) residents shall have at least two (2) direct care staff persons awake at all times and at least one (1) additional staff person immediately available on the premises when residents are sleeping. (4) During resident sleeping hours, facilities with more than one-hundred twenty (120) residents shall have at least three (3) direct care staff persons awake at all times and one additional staff person immediately available on the premises for each additional forty (40) residents or fraction thereof in the facility. B. The facility, upon request, shall provide the public and visitors the number and the names of all staff on duty. C. Maternity Shelters shall have available at all times a registered nurse or a licensed midwife. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.2.8.18 NMAC - Rn, 7 NMAC 8.2.18, 8-31-00]	A18	Scanned 10-29-09 JL RECEIVED OCT 2009 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 10/21-09

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A18	Continued From page 1 This REQUIREMENT is not met as evidenced by: Surveyor: 22697 Refer to 7.8.2.18 A. (2) During resident sleeping hours, facilities with sixteen (16) to sixty (60) residents shall have at least one (1) direct care staff person awake at all times and least one (1) additional staff person available on the premises. Based on record review and interview the facility failed to have one (1) additional staff person available on the premises during resident sleeping hours and the facility census was sixteen residents. This deficient practice has the potential to affect the quality of care and safety of all (100%) of the facility's 16 residents (R1 through R16). The findings are: A) Review the staff schedule on 9/29/09 for the month of September, 2009 revealed only one staff scheduled on the premises for the hours of 11:00 p m to 7:00 a m and the list of facility residents revealed the census to be 16 residents. B) In an interview with the administrator on 9/29/09 at 1:28 p m, the administrator acknowledge there was only on staff scheduled on the premises for the hours of 11:00 p m to 7:00 a m and the facility currently had 16 residents.	A18	Reference 7.8.2.18 A This will be corrected immediately by the administrator being present in the facility during resident sleeping hours until someone can be trained and hired or the resident population drops below 16. The resident population dropped to 15 on October 1, 2009. To insure the safety of all residents, and that this won't occur again in the future. The state license will be changed to a maximum of 15 residents. This was accomplished the week after the audit, and the proper license is now in the facility on display.	
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	A26		

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A26	Continued From page 2 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 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: Surveyor: 22697 Refer to 7.8.2.26 RESIDENT ASSESSMENT:	A26	Reference 7.8.2.26 The facility's current resident assessment is being updated to better meet the state requirements. All current residents will be re-assessed by the administrator or a consulting nurse using the updated form. The administrator or a consulting nurse will assess all future residents within 5 days of their move-in date using the same new assessment form. All resident's will be re-assessed a minimum of every 6 months. The facility will have the updated assessments in place for all residents on or before November 20, 2009.	

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A26	Continued From page 3 Based on record review and interview the facility failed to have assessments for 4 of 4 residents (R1 through R4). This deficient practice has the potential to affect the quality of care and safety of all (100%) of the facility residents. The findings are: A) Review of records on 7/30/09 revealed no assessments on file for residents R1, R2, R3, or R4. The following admission dates were noted: 1. R1 - 5/9/09, 2. R2 - 5/2/09, 3. R3 - 9/25/09, 4. R4 - 7/28/09. B) In an interview with the administrator on 9/30/09 at 10:35 a m, the administrator acknowledge there were no facility assessments for residents R1, R2, R3, or R4.	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 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.	A27		

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A27	Continued From page 4 (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: Surveyor: 22697 Refer to 7.8.2.27 B. The individual service plan must include the following: (1 - 8) Based on record review and interview the facility failed to develop Individual Service Plans (ISP) that met the eight requirements for ISPs. This deficient practice has the potential to affect the quality of care and safety of all (100%) of the facility residents. The findings are: A) Review of records on 7/30/09 revealed the ISP's for residents R1, R2, R3, and R4 all looked basically the same with no descriptive writing of the specific services, identified needs, who would provide the services, how often, when, or goals and outcomes. Most of the writing was not legible. B) In an interview with the administrator on 9/30/09 at 1:35 p m, the administrator acknowledge the ISP's for residents R1, R2, R3, and R4 all looked basically the same with no descriptive writing of the specific services, identified needs, who would provide the services, how often, when, or goals and outcomes and further agreed most of the writing was not legible.	A27	Reference 7.8.2.27 B A new ISP form that meets the state requirements will be replacing all of the current ISP's. A consulting nurse on or before November 20, 2009 will complete these. All new residents will have the new form used and completed by a consulting nurse within 14 days of their move-in date.	

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A43	7 NMAC 8.2.43 Maintenance of Building & Grounds 7.8.2.43 MAINTENANCE OF BUILDING AND GROUNDS: The building(s) must be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following: A. All electrical, fire protection signaling, mechanical, telephone, water supply, heating, fire protection, and sewage disposal systems maintained in a safe and functioning condition, including regular inspections of these systems, (as applicable). B. The building, furniture and furnishings, storage areas, and grounds of the facility must be maintained in a safe, sanitary, and presentable condition at all times. C. Storage areas must be kept free from accumulation of refuse, discarded furniture, old newspapers, that create a fire hazard. D. Floors shall be maintained stable, firm, slip-resistant and free of tripping hazards. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.43 NMAC - Rn, 7 NMAC 8.2.43, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 22697 Refer to 7.8.2.43 A. All electrical . . . systems maintained in a safe and functioning condition, including regular inspections . . . Also refer to 7.8.2.48 E. A facility must be provided with emergency lighting to light exit passageways which activate automatically upon disruption of electrical service. Based on observation and interview the facility failed to maintain the emergency lighting systems and emergency illumination exit signs in a safe and functioning condition. This has the potential to affect the safety of all (100%) of the residents,	A43	Reference 7.8.2.43 A & 7.8.2.48 E The exit signs will be maintained in working order to insure the safety of all residents. The exit signs were checked and repaired on Saturday, October 3, 2009. A log and schedule has been created for the maintenance man, and he has been trained on its use to insure the exit signs are checked on a monthly basis, and that the proper documentation is in place.	

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A43	Continued From page 6 staff, and visitors in the facility. The findings are: A) During tour of the facility on 9/29/09 at 7:13 a m, the following was observed: 1. Southwest hallway exit sign illumination goes out when the test button is pushed. 2. Northwest hallway exit sign illumination goes out when the test button is pushed. 3. Southeast hallway exit sign illumination goes out when the test button is pushed. B) In an interview with the administrator during tour of the facility on 9/29/09 at 8:28 a m, the administrator acknowledge the exit signs listed did not work when the test button was pushed. Refer to 7.8.2.43 C. Storage areas must be kept free from accumulation of refuse . . . Based on observation and interview the facility failed to keep a hazardous area used for storage free from accumulation of refuge and furniture. This has the potential to affect the safety of all (100%) of the residents, staff, and visitors in the facility. The findings are: A) Tour of the mechanical room/garage on 9/29/09 at 12:41 p m, revealed the following: 1. There were wheel chairs and miscellaneous furniture stored within 24 inches (2 feet) of the 2 gas fired hot water heaters and not at least five feet away as required. 2. There were mattresses stacked six feet high blocking access the facility's electrical panels. B) On 7/29/09 at 12:41 p m the administrator acknowledged this finding.	A43	Reference 7.8.2.43 C The clutter was removed from the garage space on October 3, 2009. The area around the water heaters (5 ft. out from the heaters) was cleared and made free of any items, and a path was cleared to gain easy access to the electrical panels. To insure that the safety of the residents, staff, and visitors in the future a storage unit was leased on October 21, 2009 to keep the these areas free from clutter. A red line will also be marked on the garage floor to maintain a 5 ft. clearance around the water heaters. A red line will also be utilized to keep a clear path to the electrical panels. This will be completed by October 30, 2009.	

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A44	Continued From page 7	A44		
A44	7 NMAC 8.2.44 Hazardous Areas 7.8.2.44 HAZARDOUS AREAS: A. Hazardous areas, as defined per NFPA 101 (Life Safety Code), on the same floor as, and in or abutting a primary means of escape or a sleeping room shall be protected by either; (1) Enclosure of at least one hour fire rating with self closing or smoke operated automatic closing fire doors having a 3/4 hour rating or; (2) Automatic fire protection (sprinkler) and separation of hazardous area with any doors self-closing or automatic-closing on smoke detection. (3) Other hazardous areas shall be enclosed with walls having at least a twenty (20) minute fire rating and doors equivalent to 1 3/4 inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. All boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one-hour. Doors to these rooms shall be 1-3/4" solid core. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have a fire resistance rating of not less than one-hour or the 1-3/4" solid core door. [7-1-64. 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.44 NMAC - Rn, 7 NMAC 8.2.44, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 22697 Refer to 7.8.2.44 A. Hazardous areas as defined per NFPA 101 (Life Safety Code) (1) Enclosure of at least one hour fire rating . . .	A44		

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A44	Continued From page 8 Based on observation and interview, the facility's practice failed to assure hazardous areas are separated by a fire resistive rating of not less than one-hour. In the event of a fire this practice has the potential to affect all staff, residents, and visitors throughout the facility. The findings are: A. Tour of the facility on 9/29/09 at 12:41 p m, revealed the following: 1. The mechanical room/garage that houses 2 gas fired hot water heaters had several pipe penetrations and holes in the dry wall that are not sealed. This is a shared wall with the living area for residents. 2. The gas fired furnace is in a room with no self closing device or smoke operating automatic closing device on the door to the room. This room abuts a corridor that is a primary means of escape. 3. The laundry room that houses two gas fired dryers has no self closing device or smoke operating automatic closing device on the door to the room. This room abuts a corridor that is a primary means of escape. B. In an interview with the administrator on 9/29/09 at 1:30 p m, the administrator acknowledged the mechanical room/garage is not sealed where the pipes penetrate through the walls and acknowledged there are holes that are not sealed. The administrator further acknowledged the furnace room and laundry room do not have self closing devices on the doors.	A44	Reference 7.8.2.44 A 1. The pipe penetrations and holes in the dry wall of the garage wall, which is shared with the residential living area, have all been sealed as of October 3, 2009. 2. A self-closing device was installed on the door to the room containing the gas fired furnace as of October 3, 2009. 3. A self-closing device was installed on the door to the laundry room as of October 3, 2009.	
A60	7 NMAC 8.2.60 Fire Alarms, Smoke Detectors, and other Equip 7.8.2.60 FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT:	A60		

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A60	Continued From page 9 A. FIRE ALARM SYSTEM: A manual fire alarm system shall be provided. The manual fire alarm must be inspected and approved in writing by the fire authority having jurisdiction. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have a fire alarm system. B. SMOKE AND HEAT DETECTION: Approved smoke detectors shall be installed on each floor to provide when activated an alarm which is audible in all sleeping areas. Areas of assembly such as the dining and living room must also be provided with smoke detectors. (1) Detectors shall be powered by the house electrical service and have battery back up. (2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room. (3) Smoke detectors must be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all enclosed kitchens and also powered by the house electrical service. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.60 NMAC - Rn, 7 NMAC 8.2.60, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 22697 Refer to 7.8.2.60 FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: Also refer to 7.8.2.43 MAINTENANCE OF BUILDING AND GROUNDS: Based on record review and interview, the facility's practice failed to ensure the fire alarm system and its components are inspected and	A60	Reference 7.8.2.60 & 7.8.2.43 The smoke alarm system shall be maintained and inspected on a monthly basis. All smoke alarms will have a sensitivity test performed at each monthly inspection. A log has been created, and the maintenance man trained on its use and necessity of monthly inspections. The inspection/sensitivity test was performed on October 3, 2009.	

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A60	Continued From page 10 maintained in accordance with (NFPA 72 H-1984,4-1), National Fire Alarm Code which requires sensitivity testing of the smoke detection devices. This deficient practice potentially affects all residents and staff throughout the facility. The licensed capacity of the facility is 15. The census after 9/30/09 at 10:00 a m was 15. The findings are: A) On 9/30/09, during a review of the facility maintenance records, there was no evidence of sensitivity testing was performed on the smoke detectors. B) On 9/30/09 at 10:25 a m the administrator acknowledged this finding. Based on observation, record review and staff interview, the facility's practice failed to ensure that the fire alarm system and its components are maintained and inspected in accordance with NFPA 72 (National Fire Alarm Code). This deficient practice potentially affects all residents and staff throughout the facility. The licensed capacity of the facility is 15. The census after 9/30/09 at 10:00 a m was 15. The findings are: A) On 9/30/09 there was no documentation indicating that the fire alarm had been inspected within the last year. B) On 7/30/09 at 10:25 a m the administrator acknowledged this finding.	A60		
A61	7 NMAC 8.2.61 Automatic Fire Protection (sprinkler) System 7.8.2.61 AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Where an automatic fire	A61		

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A61	Continued From page 11 protection (sprinkler) system is installed for total or partial coverage, the system shall be in accordance with NFPA 13 or NFPA 13D as applicable. [4-7-97; 7.8.2.61 NMAC - Rn, 7 NMAC 8.2.61, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 22697 Refer to 7.8.2.61 AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM Based on record review and interview, the facility's practice failed to provide documentation of quarterly testing, and to ensure the sprinkler system was maintained in accordance with NFPA 13, (Standard for the Installation, Testing and Maintenance of Water-Based Fire Protection Systems) and NFPA 25, (Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems). This deficient practice potentially affects all residents and staff (100%) throughout the facility. The findings are: A) On 9/30/09 during a review of the facility maintenance records, there were no sprinkler system inspection reports. B) On 7/30/09 at 10:25 a m the administrator acknowledged the sprinkler system was not being inspected quarterly by qualified personnel.	A61	Reference 7.8.2.61 The sprinkler system will be maintained and inspected on a quarterly basis with all the necessary documentation held in the proper files. An inspection is scheduled and will be completed by October 30, 2009. This inspection will be performed quarterly and properly documented. The next inspection will occur in January 2010.	
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	A66		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BUILDING _____ B. WING _____	09/30/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF LOS LUNAS	1650 LOS LENTES RD NE LOS LUNAS, NM 87031

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A66	Continued From page 12 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: Surveyor: 22697 Refer to 7.8.2.66 RELATED REGULATIONS AND CODES TITLE 7 HEALTH CHAPTER 1 HEALTH GENERAL PROVISIONS PART 9 CAREGIVERS CRIMINAL HISTORY SCREENING REQUIREMENTS 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 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	A66	Reference 7.8.2.66 As of October 20, 2009 all current employees have had the necessary information and fees sent to CCHSP. At this point in time, October 20, 2009, no employee hired after March 2009 has had the necessary information and fees submitted on or before the 20 day time limit. As the administrator, being responsible for this task, I have set up a form and calendar to track employees DOH and when the documents need to be sent to insure a timely submission.	

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A66	Continued From page 13 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. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. Specifically refer to 7.1.9.8 F. Timely Submission Based on record review and interview the facility failed to submit all fees and pertinent application information to the Caregivers Criminal History Screening (CCHS) program within 20 calendar days from date of hire for 5 of 6 staff records reviewed (S21 through S25). The findings are: A. Review of staff records on 9/30/09 revealed documentation that fees and pertinent application information had not been submitted to the CCHS program within 20 calendar days from date of hire for staff S21 through S25. The dates of hire (DOH) and dates the CCHS fees and applications were sent were recorded as follows: 1. Staff S21 - DOH 8/10/09, CCHS not sent yet, 2. Staff S22 - DOH 9/1/09, CCHS not sent yet, 3. Staff S23 - DOH 6/11/09, CCHS sent on 7/10/09, 4. Staff S24 - DOH 5/4/09, CCHS sent on 9/2/09, and	A66		

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A66	Continued From page 14 5. Staff S25 - DOH 5/9/09, CCHS sent on 9/2/09. B. In an interview with the administrator on 9/30/09 at 11:00 a m, the administrator acknowledged the fees and pertinent application information had not been sent to the CCHS program within 20 days of the date of hire for staff S21 through S25. TITLE 7 HEALTH CHAPTER 1 HEALTH GENERAL PROVISIONS PART 12 EMPLOYEE ABUSE REGISTRY 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. Refer to 7.1.12.8 A.	A66		

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A66	Continued From page 15 Based on record review and interview the facility failed to inquire with the Employee Abuse Registry (COR) prior to the date of hire (DOH) for 4 of 6 staff records reviewed (S21, S23, S24, and S25). The findings are: A. Review of staff records on 9/30/09 revealed documentation the inquiries to COR were done after the DOH for staff S21, S23, S24, and S25. The dates of hire (DOH) and the dates the inquiries to (COR) were done were recorded as follows: 1. Staff S21 - DOH 8/10/09, COR 8/31/09, 2. Staff S23 - DOH 6/11/09, COR 8/31/09, 4. Staff S24 - DOH 5/4/09, COR 5/22/09, and 5. Staff S25 - DOH 5/9/09, COR 5/22/09. B. In an interview with the administrator on 9/30/09 at 11:00 a m, the administrator acknowledged the inquiry to COR was done after the DOH for staff S21, S23, S24, and S25.	A66	Reference 7.1.12.8 A As of October 20, 2009 all current employees have the required COR documentation in their files. Most of this documentation was completed after the DOH. As the administrator, being responsible for this task, to insure this documentation is complete on or before DOH, a COR search will be run and documentation added to all applications as they are received at this facility. As of October 20, 2009, this has been done and documentation added to all applications received after September 1, 2009.	