Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 08/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A11	SURVEY/MONITORING VISITS 7.8.2.11 SURVEY/MONITORING VISITS: A. The Licensing Authority shall perform on-site survey/monitoring visits at all adult residential care facilities to determine compliance with these regulations, to investigate complaints, or to investigate the appropriateness of licensure for any alleged unlicensed facility. B. The facility must provide the Licensing Authority access to any material and information necessary for determining compliance with these requirements. C. The most recent survey inspection reports and related correspondence shall be posted in a conspicuous public place in the facility. D. Failure by the facility to provide the Licensing Authority access to premises or information, including resident records, may result in the imposition of sanctions, or license revocation. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.11 NMAC - Rn, 7 NMAC 8.2.11, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 22307 Refer to 7.8.2.11 C. Based on observation and interview with facility failed to post the most recent survey inspection report in a conspicuous place in the facility. The findings are: A. On 8/22/06 at 11:00 am during tour of the facility, the most recent survey was not observed to be posted. B. On 8/28/06 at 5:00 PM the owners stated they were not aware it had to be posted in a conspicuous place in the facility.	A11	A11 - The survey inspection report was in our Policy and Procedure manual that is available for all to view. 1. As of 08/22/06 the survey inspection report is now posted in a separate manual on a table in the common area. 2. N/A 3. Because of the obvious placement of the manual the employees will remember to place updated inspection report surveys in this manual. 4. See #3 5. Corrected 09/01/06	

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: DON — (X6) DATE: Resubmitted Date 11 Oct 06

OCT 12 2006

OCT 17 2006

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A16	7 NMAC 8.2.16 STAFF QUALIFICATIONS 7.8.2.16 STAFF QUALIFICATIONS: A facility must employ staff that meet the following qualifications: A. ADMINISTRATOR/DIRECTOR/OPERATOR: (1) Be at least twenty-one (21) years of age. (2) Demonstrate basic respect for the dignity of residents. (3) Be financially solvent and have a good credit history (credit reports must be provided to verify this requirement). (4) Be of good moral character. Applicants must comply with the requirements of the New Mexico Caregivers Criminal History Screening Act. (5) Be able to communicate with the residents and other staff members in the language spoken by the majority of the residents and other employees. (6) Have a high school diploma or its equivalent. (7) Be of sound mind, and not currently dependent upon alcohol or illegal drugs. (8) Have a proven ability to administer, direct and operate an adult residential health facility as demonstrated by education and/or work experience and provide three notarized letters of reference from persons unrelated to the applicant sent with the application as a packet to the Licensing Authority. The evidence of education and experience must be detailed in either the Application or a separate resume or curriculum vitae. B. DIRECT CARE STAFF (1) Be of at least eighteen (18) years of age. (2) Have adequate education, training, or experience to provide for the needs of the	A16	A16 - Until now we were waiting until the completion of the employees three months probationary period to request the New Mexico Caregivers Criminal History Screening. 1. Now we are going to request the required New Mexico Caregivers Criminal History Screening within 30 days of employment. 2. N/A 3. The request is now a part of our employment packet, and it is also included on our required records list which is given to each new caregiver. 4. See # 3 5. Will be corrected 10/25/06	

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A16	Continued From page 2 residents. (3) Be physically, mentally, and emotionally equipped to carry out responsibilities of resident care, including not being currently dependent upon alcohol or illegal drugs. [5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 5-28-99; 7.8.2.16 NMAC - Rn, NMAC 8.2.16, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 22307 Refer to 7.8.2.16 (4) Based on record review and interview the facility failed to comply with the requirements of the New Mexico Caregivers Criminal History Screening Act (within 30 days) for 3 of 6 employee's, caregiver #1, #3 and #5. The findings are: A. On 8/22/06 at 11:40 am, review of the personnel records for caregiver #1 (date of employment 7/21/06), caregiver #3 (date of employment 5/25/06) and caregiver #5 (date of employment: 4/05), a Criminal Background check clearance letter could not be found. B. On 8/22/06 at 11:40 am, interview with the owner stated they do not do criminal background checks until they know the staff member is going to stay, then they will do one. C. On 8/28/06 at 5:30 PM, review of the facilities Policy and Procedure manual on page 5, #5 reads direct care staff will pass a criminal background screening test with fingerprints, which was not followed.	A16		
A19	7 NMAC 8.2.19 ADMISSIONS 7.8.2.19 ADMISSIONS: No resident shall be	A19		

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A19	Continued From page 3 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. (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	A19	A19 – We had a joint meeting with Vesta Care Hospice staff and the family members before we started using the gastric tube. We do not have any residents with gastric tubs at this time. 1. We will no longer accept any new resident with gastric tube without licensing authority approval. 2. N/A 3. We currently have a form listing specific medical conditions which are not acceptable by state regulations, which apply to assisted living facilities. 4. See # 3 5. Corrected 09/01/06	

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A19	Continued From page 4	A19		

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.

(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.

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A19	Continued From page 5 (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: Surveyor: 22307 Refer to 7.8.2.19 B. (6) Based on record review and interview the facility failed to follow the requirements regarding admitting a resident who requires a higher level of care than the facility is normally permitted to provide (resident #5). The findings are: A. On 8/22/06 at 3:00 PM review of the medical record for resident #5, admitted 5/3/06, revealed he was admitted with a gastric tube. The resident required feedings to be dispensed over a 12 hour period, with flushes every six hours and medications to be given via the gastric tube. 1. There was no record that a of a team of health care professionals met jointly and decided	A19		

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A19	Continued From page 6 that resident #5's needs could be met by the facility. The licensing authority did not receive notification in writing from the facility that the team approved the admission of resident #5. B. On 8/28/06 at 5:30 PM interview with the owner stated she was not aware of this regulation. She confirmed that she had given medications and completed flushes via the gastric tube although her nursing license lapsed on 5/31/06. The resident transferred to another facility on 6/5/06.	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 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.	A22		

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A22	Continued From page 7 (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 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	A22	A22 – Refer to 7.8.2.22A. (3)(b) There were only four residents at the facility at the time of the review and each staff member new each resident intimately; therefore, we did not have pictures. Refer to 7.8.2.22A (3)(f)(g) At that time all of the residents were Hospice residents. Therefore, each time Hospice staff member visited the resident they left entries with all significant change and new plans of actions. Our staff concerns were incorporated in those notes. All administered medications are recorded in the medication records. 1. Refer to 7.8.2.22A. (3)(b) On 08/23/06 pictures were taken for each resident and inserted into the medical records book, and the missing date of birth was also added to the medical records. Refer to 7.8.2.22A (3)(f)(g) Since 08/23/06 we also have some residents who are not Hospice patients; therefore, we do entries for both, (Hospice and non-Hospice) residents. Begin on 08/22/06 all PRN administered medications are also recorded in the resident notes including the reason of use. 2. N/A 3. We have this incorporated the above procedure as part of our staff training. 4. The notes for each resident are placed in the caregiver's daily records book. 5. Corrected 08/22/06	

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A22	Continued From page 8 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 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	A22		

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A22	Continued From page 9 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: Surveyor: 22307 Refer to 7.8.2.22 A. (3)(b) Based on record review and interview the facility failed to have a recent photograph for 2 of 5 sampled resident's, #3 and #5; and the date of birth for resident #5, in the resident record within 30 days. The findings are: A. On 8/22/06 at 2:00 PM review of the medical record for resident #5 admitted on 5/3/06, a date of birth nor a photograph could be found. Resident #3, admitted 11/14/05 did not have a photograph. B. On 8/22/06 at 2:00 PM, interview with the owner and her husband stated they don't take pictures of the resident's when they are admitted to the facility and were not aware this needed to be done. Refer to7.8.2.22 A. (3)(f)(g) Based on observation, record review and interview the facility failed to make entries by direct care staff in the medical record which included significant information for 5 of 5 sampled resident's, #1 through #5. The findings are: A. On 8/22/06 at 1:00 PM review of the medical record for resident #1, was admitted on 8/4/06	A22		

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A22	Continued From page 10 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), leg edema and on Hospice care. Observation of resident #1's lower extremities were noted to be edematous and weepy with fluid. The Medication Administration Record for the month of August shows the resident was medicated with Roxanol (ordered when necessary) for pain/shortness of breath every night from 8/10-8/18/06. Resident #1 was also administered Phenergan (ordered when necessary) for nausea/vomiting on 8 different occasions from 8/10-8/21/06, yet no documentation by direct care staff of the facility could be found, or since the resident was admitted. B. On 8/22/06 at 1:30 PM review of the medical record for resident #2, was admitted on 11/14/05 with a diagnosis of confusion, agitation, dementia, Parkinson's disease and on Hospice care. The resident was observed to be in a wheelchair and in need of assist with all Activities of Daily Living (ADL's). On 8/22/06 at 12:30 PM the wife stated the resident needed to be fed and was observed feeding her husband. During review of the MAR resident #2 had received a course of antibiotics from 8/17-8/23/06. On 8/22/06 at 1:00 PM interview with the owner's husband stated the resident had an incident on 8/18/06 in which he was hitting the wall in his room and received a small skin tear to his left hand. There was no evidence of documentation by direct care staff, of the facility, regarding his daily needs, the course of antibiotics and outcome, or the incident that happened on 8/18/06. C. On 8/22/06 at 2:00 PM review of the medical record for resident #3, was admitted on 8/4/06 with a diagnosis of heart disease, status post left	A22		

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A22	Continued From page 11 hip fracture, atrial fib, Congestive Heart Failure (CHF), Chronic Obstructive Heart Disease (COPD) and dementia. The resident assessment dated 8/4/06 states resident needs assist with all ADL's, is incontinent, on oxygen, wanders, etc. The MAR for the month of August shows the resident received Roxanol for pain/shortness of breath between 8/8/9-8/22/06 and was on a course of antibiotic therapy from 8/3-8/7/06. There was no evidence of documentation by direct care staff of the facility regarding his daily needs, the use of pain medications and the course of antibiotic treatment with the outcome, or since the resident was admitted. D. On 8/22/06 at 2:30 PM review of the medical record for resident #4, was admitted on 6/22/06 with a diagnosis of Alzheimer's disease and on Hospice care. The resident assessment dated 6/22/06 (incomplete) shows resident needs assist with all ADL's and is incontinent. The MAR for the month of August shows the resident was administered Ativan (an anti-anxiety medication) 17 times in the month of August and Ibuprofen 10 times in the month of August. There was no evidence of documentation by direct care staff of the facility regarding daily needs or why the medications listed were used (behaviors displayed for the Ativan), or since the resident was admitted. E. On 8/22/06 at 3:00 PM review of the medical record for resident #5, was admitted on 5/3/06 (discharged on 6/5/06) with a diagnosis of S/P CVA (Cerebral Vascular Accident) with a gastric tube. The resident required total care. The MAR for the month of August shows the resident received a course of antibiotics from 8/4-8/10/06 and was suctioned 15 times in the month of August. There was no evidence of	A22		

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	2073	A. BUILDING _____ B. WING _____	C 08/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

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A22	Continued From page 12 documentation by direct care staff, of the facility, regarding his daily needs, the course of antibiotics and outcome, the reason he was suctioned or since the resident was admitted. F. On 8/22/06 at 3:30 PM interview with the owner and her husband stated they only chart if something happens (discharge, vital signs, when they don't look good).	A22		
A23	7 NMAC 8.2.23 FAC. REPORTS,RECS.,P & PS & RULES 7.8.2.23 FACILITY REPORTS/RECORDS/POLICIES AND PROCEDURES/ AND RULES: A. REPORTS AND RECORDS: Each facility must keep the following reports, records, and policy and procedures on file at the facility and make them available for review upon request of the Licensing Authority: (1) Fire Inspection Report. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have fire inspection reports. (2) Copy of the last survey conducted by the Licensing Authority, adverse actions or 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	A23	A23 – Refer to 7.8.2.23 A. (11) There are two days of orientation given by License Managers and the current staff. 1. We add the two day orientation check list to the employee file. 2. N/A 3. We will continue maintaining an employee checklist which includes: fire safety, first aid, safe food handling practices, confidentiality of records and resident information, infection control, resident rights, providing quality of care based on current resident need, reporting requirement for Abuse Neglect or Exploitation along with continuous inservice per our policy and procedures manual. 4. See #3 5. Corrected 09/01/06	

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A23	Continued From page 13	A23		

family members living in the facility.

(5) One (1) month of menus planned and as served.

(6) Record of fire drills: A record of all fire drills conducted at the facility. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to hold or record fire drills.

(7) Written emergency plans and policies and procedures for medical emergencies, power failure, fire or natural disaster. Such plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes and refuge areas, responsibilities of personnel.

(8) Licensing regulations: A copy of these regulations (Requirements for Adult Residential Care Facilities, 7.8.2 NMAC).

(9) Custodial Drug Permit: A valid Custodial Drug Permit issued by the State Board of Pharmacy for those facilities licensed pursuant to these regulations. EXCEPTION: Adult residential care facilities with only one (1) resident are not required to have a custodial drug permit.

(10) Vaccination of pets in the facility.

(11) Staff training.

(a) At orientation and on-going.

(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.

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A23	Continued From page 14 (j) Reporting requirements for Abuse, Neglect or Exploitation. (12) A copy of License. (13) Employee personnel records, including an application for employment, TB certificates, training records, and personnel actions. (14) A copy of all WAIVERS/VARIANCES granted by the Licensing Authority. (15) A copy of the floor plans as approved for licensure. B. RULES: Prior to placement in or admission to a facility, a prospective resident or his/her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to but not limited to the following: (1) The use of tobacco and alcohol. (2) The use of the telephone. (3) Operation of television, radio, and stereo. (5) Use and safekeeping of personal property. (6) Meals. (7) Use of common areas. (8) Electric blankets or appliances used by residents. C. POLICIES AND PROCEDURES: All 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.	A23		

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A23	Continued From page 15 (6) Staff and resident fire and safety training. (7) Smoking. (8) The facility's bed hold policy. (9) Admission agreement. (10) Admission records. (11) Resident records. (12) Program Narrative. (13) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (14) Personnel policies. (15) Identifying and safeguarding resident possessions. (16) Securing medical assistance if a resident's own physician is not available. (17) NOTE FOR MATERNITY SHELTERS ONLY: In addition to the required policy and procedure topics listed above, Maternity Shelters shall have written policies and procedures regarding infant formula, feeding and equipment, and laundering of infant linen and diapers. (18) Staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles. (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: Surveyor: 22307 Refer to 7.8.2.23 A. (11) Based on record review and interview the facility failed to provide documentation that staff at the facility had been trained at orientation and	A23		

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A23	Continued From page 16 on-going regarding staff responsibilities, fire safety, first aid, safe food handling practices, confidentiality of records and resident information, infection control, resident rights, providing quality of care based on current resident need, reporting requirements for Abuse, Neglect or Exploitation for 4 of 6 caregivers (#1 - #4). The findings are: A. On 8/22/06 at 11:30 AM, review of the personnel files for caregiver #1, hired 7/21/06, caregiver #2, hired 8/18/06, caregiver #3, hired 5/25/06 and caregiver #4, hired 8/11/06 no record of training could be found. B. On 8/28/06 at 5:30 PM, interview with the owner and her husband confirmed they had the form but had not completed them on their employees.	A23		
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.	A26	A26 All residents at that time were Hospice patients and Hospice made there own assessments. 1. We currently have also some residents who are not Hospice patients; therefore, we have incorporated our own assessment for both Hospice and non-Hospice residents. 2. N/A 3. We have incorporated the above procedure as part of our staff training. 4. Assessment forms are included in the new resident admission package. 5. Corrections: 09/01/06	

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A26	Continued From page 17 (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: 22307 Based on observation, record review and interview the facility failed to complete a resident assessment within 5 days of admission in order to determine the level of function and if the resident's needs can be met by the facility for 5 of 5 sampled residents, #1-#5. The findings are: A. On 8/22/06 at 1:00 PM review of the medical record for resident #1, admitted 8/4/06 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and on oxygen, leg edema and on Hospice care revealed a resident assessment could not be found in the chart. A resident	A26		

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A26	Continued From page 18 assessment form was not added to the chart until 8/28/06 and had been back dated to 8/15/06. B. On 8/22/06 at 1:30 PM review of the medical record for resident #2, admitted on 11/14/05 with a diagnosis of confusion, agitation, dementia, Parkinson's disease and on Hospice care. The resident was observed to be in a wheelchair and in need of assist with all Activities of Daily Living (ADL's). A resident assessment had not been completed within 5 days of admission. C. On 8/22/06 at 2:00 PM review of the medical record for resident #3, admitted on 8/4/06 with a diagnosis of heart disease, status post left hip fracture, atrial fib, Congestive Heart Failure (CHF), Chronic Obstructive Heart Disease (COPD) and dementia. The resident assessment dated 8/4/06 stated resident needs assist with all ADL's, is incontinent, on oxygen, wanders, etc. The resident assessment form was not complete. D. On 8/22/06 at 2:30 PM review of the medical record for resident #4, admitted on 6/22/06 with a diagnosis of Alzheimer's disease and on Hospice care. The resident was observed to need assist with all ADL's and was incontinent. The resident assessment form dated 6/22/06 was not complete. E. On 8/22/06 at 3:00 PM review of the medical record for resident #5, admitted on 5/3/06 (discharged on 6/5/06) with a diagnosis of S/P CVA (Cerebral Vascular Accident) with a gastric tube. The resident required total care. A resident assessment could not be found in the chart. F. On 8/22/06 at 3:00 PM interview with the	A26		

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A26	Continued From page 19 owner and her husband showed me a blank form and stated one resident was perfect. They also stated they had not completed one on resident #5.	A26		
A27	7 NMAC 8.2.27 INDIVIDUAL SERVICE 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. (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: 22307 Based on observation, record review and interview the facility failed to develop and	A27	A27 - All residents at that time were Hospice patients and Hospice made there own individual service plan of care. 1. We currently have also some residents who are not Hospice patients; therefore, we will incorporate our own individual service plan of care form for both Hospice and non-Hospice residents. 2. N/A 3. We will incorporate the above procedure as part of our staff training. 4. Individual service plan of care forms will be included in the new resident admission package. 5. Corrections: 10/25/06	

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A27	Continued From page 20 implement an Individual Service Plan (ISP) within 14 days of admission for 5 of 5 sampled residents, #1-#5. The findings are: A. On 8/22/06 at 1:00 PM review of the medical record for resident #1, admitted 8/4/06 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and on oxygen, leg edema and on Hospice care revealed an ISP could not be found in the chart. B. On 8/22/06 at 1:30 PM review of the medical record for resident #2, admitted on 11/14/05 with a diagnosis of confusion, agitation, dementia, Parkinson's disease and on Hospice care. The resident was observed to be in a wheelchair and in need of assist with all Activities of Daily Living (ADL's). An ISP could not be found in the chart. C. On 8/22/06 at 2:00 PM review of the medical record for resident #3, admitted on 8/4/06 with a diagnosis of heart disease, status post left hip fracture, atrial fib, Congestive Heart Failure (CHF), Chronic Obstructive Heart Disease (COPD) and dementia. The resident assessment dated 8/4/06 stated resident needs assist with all ADL's, is incontinent, on oxygen, wanders, etc. An ISP could not be found in the chart. D. On 8/22/06 at 2:30 PM review of the medical record for resident #4, admitted on 6/22/06 with a diagnosis of Alzheimer's disease and on Hospice care. The resident was observed to need assist with all ADL's and was incontinent. An ISP could not be found in the chart. E. On 8/22/06 at 3:00 PM review of the medical record for resident #5, admitted on 5/3/06 (discharged on 6/5/06) with a diagnosis of S/P CVA (Cerebral Vascular Accident) with a gastric	A27		

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A27	Continued From page 21 tube. The resident required total care. An ISP could not be found in the chart F. On 8/28/06 at 6:00 PM interview with the owner and her husband stated they were not aware this had to be done.	A27		
A35	7 NMAC 8.2.35 CUSTODIAL DRUG PERMIT 7.8.2.35 CUSTODIAL DRUG PERMIT: Any facility licensed pursuant to these regulations who supervises the administration, self-administration, or safeguards medications for residents, must have a current custodial drug permit issued by the State Board of Pharmacy. EXCEPTION: Adult residential care facilities with one (1) resident are not required to have a custodial drug permit. A. PROCUREMENT, LABELING, AND STORAGE: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as required by the individual or specified by the individual's health care plan. The facility shall procure, label, and store medications for residents in a manner which shall be in compliance with state and federal laws. (1) All medications, including non-prescription drugs, will be stored in a locked compartment or in a locked room, as approved by the Board of Pharmacy, and the key will be in the care of the director or designee. (2) Internal medication must be kept separate from external medications. Drugs to be taken by mouth will be separated from all other dosage forms. (3) A separate locked compartment will be available in the refrigerator for those items labeled "keep in refrigerator." The refrigerator temperature will be kept between thirty-five (35)	A35	A35 – Refer to 7.8.2.35A. (1) There is a medication closet which is kept locked at all times when the caregiver is not nearby. Refer to 7.8.2.35 B. At that time the facility, had and currently has a contract with a consulting pharmacist. We assumed he was following all of the NM Board of Pharmacy regulations.	

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A35	Continued From page 22 and forty-five (45) degrees Fahrenheit. A thermometer is required to be kept in the refrigerator. (4) All medications, including non-prescription medications, must be stored in separate compartments for each resident and all medications will be labeled with the residents' names. (5) A resident may be permitted to keep his/her own medication in a secure place in his/her room for self-administration if the physician's report has deemed it appropriate that the resident do so. (6) The facility may not require the resident to purchase prescriptions from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes must comply with National Fire Protection Association (NFPA) 99. B. CONSULTING PHARMACIST: The facility shall maintain records demonstrating the consulting pharmacist provides the following: (1) Reviews the medication regimen as needed, but at least quarterly (every three (3) months), to determine that all medications and records are accurate and current. All irregularities must be reported to the Director of the facility and these irregularities must be acted upon. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation is provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications.	A35		

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A35	Continued From page 23 [7-1-64, 9-15-70, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.35 NMAC - Rn, 7 NMAC 8.2.35, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 22307 Refer to 7.8.2.35 A. (1) Based on observation and interview the facility failed to keep all medications in a locked compartment and the key in the care of the director or designee. The findings are: A. On 8/22/06 at 11:00 AM, during the initial tour and throughout the survey the cabinet (located in the living room) which contained resident medication was found to be unlocked and the keys were in the lock. Most of the time staff were not within eye range of the cabinet, leaving it accessible to wandering resident's and family members. B. On 8/28/06 at 2:30 PM interview with the owners husband stated "I have to keep them locked, even when I'm here?" Refer to 7.8.2.35 B. Based on record review and interview the facility failed to provide documentation of medication regimen reviews by a consulting pharmacist at least quarterly (since the facility opened in April 2005) to determine that all medications and records are accurate and current. The findings are: A. On 8/22/06 at 12:30 PM, quarterly pharmacy reports could not be found. A system of receipt	A35		

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	2073	A. BUILDING _____ B. WING _____	C 08/28/2006

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A35	Continued From page 24 and disposition of all drugs could not be found. B. On 8/22/06 at 1:15 PM, the owner and her husband stated the pharmacist was out in May or June but didn't leave them a report. They stated they were not always there. On 8/22/06 at 4:00 PM the owner stated the pharmacist was out of the country.	A35		
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 resident's record. D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and side-effects.	A36	A36 – Refer to 7.8.2.36 B At that time, we had a verbal agreement with the resident, or the resident's guardian to administer medications by our staff. In our facility medication can be administered by License Nurses and unlicensed staff who have completed an approved assistance with medication training program, or be licensed by the state of New Mexico. Refer to 7.8.2.36 F The facility maintains a MAR documents. Refer to 7.8.2.36 G Our staff was utilizing weekly medication disbursement containers that arrived with the residents at the time of the interview.	

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A36	Continued From page 25 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: (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.	A36	1. Refer to 7.8.2.36 B We no longer except verbal agreements to administer medication to our residents. We only administer medication per a written and signed agreement by the resident, or the resident's guardian. We are now tracking and recording the licensure and certification including the expiration dates of each employee regularly. We have reinforced to our employees who do not have the required certifications not administer medication. Refer to 7.8.2.36 F The misplaced MAR was found. Refer to 7.8.2.36 G This procedure was discontinued the day of the interview. 2. Refer to 7.8.2.36 B, F, G N/A 3. Refer to 7.8.2.36 B We will continue maintaining an employee inservice as per or policy and procedures manual. Refer to 7.8.2.36 F Our employees are trained to not remove MAR documents from the book. There is also a DO NOT REMOVE LABLE affixed to the book. Refer to 7.8.2.36 G, It is now a requirement that each employee reads and signs a copy of our policies and procedures and this will be maintained in the employee's file. Will be corrected by 10/25/06 4. Refer to 7.8.2.36 B, F, G See #3 5. Refer to 7.8.2.36 B, F, Corrected: 09/01/06 Refer to 7.8.2.36 G Corrected 08/22/06	

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A36	Continued From page 26 (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: Surveyor: 22307 Refer to 7.8.2.36 B. Based on record review and interview the facility failed to obtain written consent by the resident or the resident's guardian for the staff to assist the resident with medications for 5 of 5 sampled residents, #1-#5. The facility also failed to ensure that staff assisting with medications have successfully completed an approved assistance with medication training program or be licensed by the state of New Mexico to administer medications for 2 of 6 employees, caregiver #1 and the owner. The findings are: A. On 8/22/06 at 3:30 PM review of the medical records for resident #1 through #5, a written consent by the resident or their guardian to assist with medications was not found. Review of the personnel record for caregiver #1 did not have a certificate to assist with medications and was observed on 8/22/06 at 12:30 PM giving medications. The owner did not have a current	A36		

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A36	Continued From page 27 nursing license (license expired on 5/31/06) to administer medications, although she signed out as having given the medications from 6/1/06 to present on the Medication Administration Record (MAR). B. On 8/22/06 at 11:15 AM, interview with caregiver #1 stated she did not have a certificate to assist with medications but had been doing so. The owner also confirmed that she administered medications when she worked, although her nursing license had expired on 5/31/06. Refer to 7.8.2.36 F. Based on record review and interview the facility failed to have a MAR documenting medications administered for 1 of 5 sampled resident's, resident #5. The findings are: A. On 8/22/06 at 3:00 PM, review of the medical record for resident #5, who's diagnosis includes S/P CVA and gastric-tube, a MAR for the month of June could not be found. The resident was receiving medications through the gastric tube, as well as feedings over 12 hours with flushes. B. On 8/22/06 at 3:30 PM interview with the owner stated she did not know what happened to the MAR. Refer to 7.8.2.36 G. Based on record review and interview the facility failed to ensure that any medications removed from the pharmacy container or blister pack are given immediately and documented by the person assisting. The findings are: A. On 8/22/06 at 12:30 PM, caregiver #1 was	A36		

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A36	Continued From page 28 observed giving pre-poured medications to three different resident's. After giving the medications she did not sign them out as given. On 8/22/06 at 11:15 AM when asked what the pre-poured medications were, caregiver #1 stated she did not know. Caregiver #1 stated that the owner or her husband got the medications ready for the week by placing them in a container labeled Monday-Sunday, Breakfast, lunch, dinner. B. On 8/22/06 at 12:30 PM interview with the owner stated she also gave medications. That she pours the medications for the week (including narcotics) and that the caregivers or her husband distributes the medication and she signs the MAR. The owner stated that she signed the MAR because she prepares them for a week. On 8/22/06 at 1:00 PM a narcotic count was completed with the owner and found to be inaccurate. Resident #4 had 12 ativan left in a bubble pack but no sign out sheet could be found. Resident #2 had a narcotic sheet that listed 8 ativan left, but no ativan could be found. The owner stated that not all the pharmacies provided a narcotic sign off sheet, so the narcotics were not documented as given. C. Review of the Policy and Procedures (page 40) reads to never pre-pour medications, to sign out all controlled medications on the narcotic count sheet and a count is to be completed by oncoming and off going shifts. The facility Policy and Procedures were not being followed.	A36		