STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5883	A. BUILDING _____ B. WING _____	11/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTS THAT CARE ASSISTED LIVING, LLC	9977 BUCKEYE STREET NW ALBUQUERQUE, NM 87114

(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
A20	7 NMAC 8.2.20 ADMISSIONS/DISCHARGE AGREEMENT 7.8.2.20 ADMISSION/DISCHARGE AGREEMENT: The facility must establish an admission agreement for each resident. A. The admission agreement must include the following information: (1) The parties to the agreement. (2) The scope of services to be provided. (3) The cost of services and method of payment. (4) The circumstances under which the Agreement may be terminated. (a) Termination of admission agreements shall be upon at least fifteen (15) days written notice, to the resident and his or her agent or guardian, where applicable, unless the resident requests termination. (b) The facilities bed hold policy. (c) An admission/discharge agreement may provide for termination by the facility when the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility. (d) Termination of an admission agreement by the facility is permitted in emergency situations for the following reasons: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; the safety or health of individuals in the facility is endangered; the resident has failed to pay for a stay at the facility, as defined in the admission agreement; the facility ceases to operate or is no longer able to provide services to the resident; and due to sanctions or remedies imposed by the Department. B. A new or amended admission agreement must be executed whenever services, costs or	A20	E.J. Mcconnell 01-24-08	

Division of Health Improvement

Rosa Estrada

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

TITLE: owner

(X6) DATE: 1/23/8

JAN 2 4 2008

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A20	Continued From page 1 other material terms are changed. [7-11-86, 1-11-90, 4-7-97; 7.8.2.20 NMAC - Rn, 7 NMAC 8.2.20, 8-31-00] [redacted]	A20	7.8.2.20B A, B, C, D 1) An Addendum Admission Agreement form has been created and will be used for any and all rate increases. The Addendum Admission Agreement Form will be sent to the family member or POA when there is a rate increase of any kind. The form will be sent out 30 days prior to all rate increase. In the event of a health care change, a team meeting will be held and a rate increase will be discussed and if needed a new Addendum Admission Agreement will be signed at that time. The form requires the family member or POA to sign acknowledging they are aware and agree to the rate increase. 2) All current resident's files will be pulled and if any rate increases took place in the past, the Addendum Admissio Agreement form will be sent to the family member or POA to be sign and return and will be kept in the resident's file. 3) Administrator will make sure that when a rate increase is needed, the Addendum Admissions Agreement form will be sent to the family member or POA to be signed and returned. The new agreement will be kept in the resident's file. 4) All Addendum Admissions Agreement have been completed and signed and are in the files as of January 5, 2008.	

Based on records review and interview, the facility failed to execute a new or amended admission agreement whenever services, costs, or other material terms change for 3 of 4 sampled residents (75%). The findings are:

A. Review of R1's records revealed an admission agreement dated 10/28/05. Further review of R1's records revealed a letter from the facility dated 8/28/07 informing the resident/surrogate decision maker that costs would increase 3% beginning on 10/1/07 but there was no evidence of a new or amended admission agreement.

B. Review of R3's records revealed an admission agreement dated 7/1/07. Further review of R3 ' s records revealed a letter from the facility dated 8/28/07 informing the resident/surrogate decision maker that costs would increase 3% beginning on 10/1/07 but there was no evidence of a new or amended admission agreement.

C. Review of R4's records revealed an admission agreement dated 3/24/07. Additional review of R4's records revealed a letter from the facility dated 4/9/07 informing the resident/surrogate decision maker that costs would increase beginning on 5/1/07. Further review of R4's records revealed a second letter from the facility dated 8/28/07 informing the resident/surrogate decision maker that costs would increase 3% beginning on 10/1/07 but there was no evidence of new or amended admission agreements.

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A20	Continued From page 2 D. During an interview with S11/Co-Owner on 11/13/07 at 11:00 a.m., S11/Co-Owner acknowledged that the facility failed to execute new or amended admission agreements with R1, R3, and R4 reflecting the cost increases.	A20		
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. (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	A22		

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A22	Continued From page 3 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 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	A22		

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A22	Continued From page 4 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 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]	A22		

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A22	Continued From page 5 [redacted] is not met as evidenced [redacted] Based on records review and interview, the facility failed to ensure that entries in each resident's record were authenticated with the signature of the person making the entry for 4 of 4 sampled residents (100%). The findings are: A. Review of R1-R4's daily direct care notes from approximately 10/07 through 11/13/07 revealed no authenticating signatures of the persons making the entries. B. During an interview with S11/Co-Owner on 11/13/07 at 11:00 a.m., S11/Co-Owner acknowledged that the facility failed to ensure that R1-R4's daily direct care notes were authenticated with the signature of the person making the entries. [redacted] 7.8.2.22A.(2)(c) Based on records review and interview, the facility failed to maintain the following within 5 days of admission: an admission physical examination report or hospital discharge summary for 3 of 4 sampled residents (75%). The findings are: A. Review of R2's resident records revealed an admission date of 9/6/07 but no admission physical examination report or hospital discharge summary. B. Review of R3's resident records revealed an admission date of 7/1/07 but no admission physical examination report or hospital discharge summary.	A22	7.8.2.22A A, B. 1. A form has been created for the employees to sign and initial. This form will be at the beginning of the MAR. The Administrator will follow up to make sure the employee are signing or initialing all entries on the MAR. 2. This form will be printed along with the new MAR each month. 3. The Administrator will make sure the form is signed and initialed by all employees. 4. The forms were in place and all employees signed and initialed the form by December 19, 2007.	

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A22	Continued From page 6 C. Review of R4's resident records revealed an admission date of 3/24/07 but no admission physical examination report or hospital discharge summary. D. During an interview with S11/Co-Owner on 11/13/07 at 11:00 a.m., S11/Co-Owner stated, "the physicians keep the physical exams on file in their offices." S11/Co-Owner acknowledged that the facility failed to maintain documentation of R2-R4's admission physical examination reports or hospital discharge summaries.	A22	7.8.22A (2) A, B, C, D 1. The AHCA 1823 form is now in place and will be filled out by a physician within 5 days of admitting a resident into the facility unless we have a hospital discharge summary for all new residents. 2. Administrator will check and make sure all current resident's files have the proper AHCA 1823 form or a hospital discharge summary. 3. The AHCA 1823 form has been added to all new resident's admittance packet. Administrator will make sure the form is filled out by a physician if there is not a hospital discharge summary upon admitting any new resident. 4. All files that do not have a hospital discharge summary will have a AHCA 1823 form filled out by a physician A physician has been scheduled to do the physicals and will be completed by January 11, 2008.	
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	A23		

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A23	Continued From page 7	A23		

Environmental Health Authority having jurisdiction, are not required to have a survey on file provided the exemption letter is on file.

(4) TB test results of staff or any of their family members living in the facility.

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

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

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

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

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

(10) Vaccination of pets in the facility.

(11) Staff training.

(a) At orientation and on-going.

(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

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A23	Continued From page 8	A23		

precautions and linen handling).

(h) Resident rights.

(i) Providing Quality Resident care based on current resident need.

(j) Reporting requirements for Abuse, Neglect or Exploitation.

(12) A copy of License.

(13) Employee personnel records, including an application for employment, TB certificates, training records, and personnel actions.

(14) A copy of all WAIVERS/VARIANCES granted by the Licensing Authority.

(15) A copy of the floor plans as approved for licensure.

B. RULES: Prior to placement in or admission to a facility, a prospective resident or his/her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to but not limited to the following:

(1) The use of tobacco and alcohol.

(2) The use of the telephone.

(3) Operation of television, radio, and stereo.

(5) Use and safekeeping of personal property.

(6) Meals.

(7) Use of common areas.

(8) Electric blankets or appliances used by residents.

C. POLICIES AND PROCEDURES: All 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

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A23	Continued From page 9	A23		

the facility provides such services.

(4) Reporting of incidents, including abuse, neglect, and exploitation.

(5) Handling of complaints.

(6) Staff and resident fire and safety training.

(7) Smoking.

(8) The facility's bed hold policy.

(9) Admission agreement.

(10) Admission records.

(11) Resident records.

(12) Program Narrative.

(13) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives.

(14) Personnel policies.

(15) Identifying and safeguarding resident possessions.

(16) Securing medical assistance if a resident's own physician is not available.

(17) NOTE FOR MATERNITY SHELTERS ONLY: In addition to the required policy and procedure topics listed above, Maternity Shelters shall have written policies and procedures regarding infant formula, feeding and equipment, and laundering of infant linen and diapers.

(18) Staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles.

(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]

[redacted]

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A23	Continued From page 10 Based on records review and interview, the facility failed to maintain records of orientation and ongoing (annual) staff training in the following topics: first aid, safe food handling, confidentiality of records, infection control, resident ' s rights, quality care based on need, incident reporting requirements for abuse, neglect, and exploitation for 3 of 3 sampled staff (100%). The findings are: A. Review of S11/Co-Owner's personnel records revealed no documentation of ongoing training in the following topics: first aid, safe food handling, confidentiality of records, infection control, resident ' s rights, quality care based on need, and incident reporting requirements. B. Review of the Administrator/Co-Owner's personnel records revealed no documentation of ongoing training in the following topics: first aid, safe food handling, confidentiality of records, infection control, resident ' s rights, quality care based on need, and incident reporting requirements. C. Review of S12's personnel records revealed a hire date of 6/2/07. S12's records revealed no documentation of orientation training in the following topics: safe food handling, confidentiality of records, infection control, resident ' s rights, quality care based on need, and incident reporting requirements. D. During an interview with S11/Co-Owner on 11/13/07 at 11:00 a.m., S11/Co-Owner acknowledged that the facility failed to maintain records of orientation and ongoing (annual) training in the above topics for S11, S12, and the Administrator.	A23	7.8.2.23A (11) (a,c-j) A, B, C, D 1) A form has been created with a list of all required training of employees. All employees will be trained in all of the following: First Aid, Safe Food Handling, Confidentiality of Records, Infection Control, Resident's Rights, Quality Care Based on Needs, and Incident Reporting Requirements at Orientation and Annually. Employee orientation will be completed before employee is allowed to care for residents.Upon completion of training the form will be signed off by the employee, trainer and Administrator and kept in the employees file. 2) Administrator will make sure all current staff have received training on all the required training: First Aid, Safe Food Handling, Confidentiality of Records, Infection Control, Resident's Rights, Quality Care Based on Needs, and Incident Reporting Requirements. 3) After orientation, the employee will meet with the Administrator, the Administrator will go over all the required training and make sure the employee received all the training. The Administrator will sign the form and the form will be put in the employees file. 4) The required training with all current employee will be completed by January 11, 2008. Incident Management Training will be scheduled and a mandatory letter will be put in each employees file stating they must attend the training.	

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A23	Continued From page 11 Based on records review and interview, the facility failed to maintain employee personnel records, including employment applications, on file at the facility and make them available for review for 2 of 3 sampled staff (66.6%). The findings are: A. Review of personnel records revealed no evidence of employment applications or resumes for S11/Co-Owner and the Administrator/Co-Owner. B. During an interview with S11/Co-Owner on 11/13/07 at 11:00 a.m., S11/Co-Owner acknowledged that the facility failed to maintain employment applications/resumes on file at the facility for S11 and the Administrator.	A23	7,2,23A (13) A, B 1) An application was completed by the Co-Owner and was placed in her file along with all other required paper work. 2) Administrator/Co-Owner records will be kept in a safe place and monitored to make sure all proper paper work is in the file. 3) The Administrator/Co-Owner file will be checked regularly to make sure all paper work is in the file. 4) This was completed by December 20, 2008	
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	A27		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTS THAT CARE ASSISTED LIVING, LLC	9977 BUCKEYE STREET NW ALBUQUERQUE, NM 87114

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A27	Continued From page 12 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] [redacted] is not met as evidenced Based on records review and interview, the facility failed to develop and implement individual service plans (ISP ' s) within 14 days of admission and ensure that the ISP's were reviewed by a licensed nurse for 1 of 4 sampled residents (25%). The findings are: A. Review of R4's resident records revealed an admission date of 3/24/07. R4's resident records revealed one ISP signed as reviewed by a licensed nurse on 7/3/07. B. During an interview with S11/Co-owner on 11/13/07 at 11:00 a.m., S11/Co-Owner acknowledged that the facility failed to develop R4's ISP within 14 days of admission. However, R4's ISP was developed and reviewed by a licensed nurse on 7/3/07 and the facility is currently in compliance with this requirement.	A27	7.8,2,27A A, B 1) The violations was corrected by July 3, 2007. 2) Administrator will make sure the ISP is done within 14 days of admission 3) Administrator will develop a check list with all requirements necessary upon admitting a new resident. 4) All Resident's files were completed on July 3, 2007	
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	A36		

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responsible for the administration of medications.

B. Facility staff may assist a resident with medications if written consent by the resident is given to the director of the facility or their designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with medications. All staff assisting with medications shall have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications.

C. No medications, including over the counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order by the physician and entry into the resident's record.

D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and side-effects.

E. Medications prescribed for one resident shall not be used for another resident.

F. The facility shall have a Medication Administration Record (MAR) documenting medications administered to residents, including over-the-counter medications. This documentation shall include:

(1) Name of resident.
(2) Date started.
(3) Drug product name.
(4) Dosage and form.
(5) Strength of drug.
(6) Route of administration (e.g. "by mouth").
(7) How often medication is to be taken.
(8) Time taken and staff initials.

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(9) Dates when the medication is discontinued or changed.

(10) The name and initials of all staff administering medications.

G. Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting.

H. PRN Medications: The use of PRN medications must be closely monitored and supervised by the facility and is based on one or more of the following conditions:

(1) The resident is capable of determining when the medication is needed.

(2) The resident's physician has provided detailed instructions to the pharmacy regarding the administering of the medication. The physicians instruction for a PRN medication shall include:

(a) Symptoms that might indicate the use of the medication.

(b) Exact dosage to be used.

(c) The exact amount of medication to be used in a 24 hour period.

(d) Directions as to what to do if the symptoms persist.

(e) Possible interactions or side-effects that might occur.

(f) Manufacturer's label information for directions if deemed adequate by the physician.

I. The facility must report all medication errors to the physician.

J. The facility shall develop and follow a written policy for unused, outdated, or recalled medications being kept in the facility.

[7-1-64, 9-15-70, 7019074, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.36 NMAC - Rn, 7 NMAC 8.2.36, 8-31-00]

[redacted] is not met as evidenced [redacted]

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A36	Continued From page 15 [redacted] Based on observation, record review, and interview, the facility failed to obtain physician's orders prior to starting medication for 2 of 4 sampled residents (50%). The findings are: A. Observation of R2's secured medications on 11/13/07 at 1:00 p.m. revealed a bottle of Namenda, 10 mg/1 per day. Review of R2's physician's orders revealed an order for Namenda 5mg./1 per day. Review of R1's 11/07 MAR revealed an entry for Namenda 5mg./ 1 per day with staff initials attesting that the medication had been given. B. Observation of R2's secured medications on 11/13/07 at 1:00 p.m. revealed a bottle of megestrol acetate. Review of R2's physician's orders revealed no order for megestrol acetate. Review of R2's 11/07 MAR revealed staff initials attesting that the medication had been given. C. Observation of R3's secured medications on 11/13/07 at 1:00 p.m. revealed a bottle of oxybutynin. Review of R3's physician's orders revealed no order for oxybutynin. Review of R3's 11/07 MAR revealed staff initials attesting that the medication had been given. D. During an interview with S11/Co-Owner on 11/13/07 at 2:00 p.m., S11/Co-Owner revealed that R2's physician changed the strength of her Namenda from 5 mg. to 10 mg. on an unknown date and the facility gave R2 the stronger dosage without documented physician's orders. Additionally, S11/Co-Owner acknowledged that the facility started R2's megestrol acetate and R3's oxybutynin without documented physician's orders.	A36	7.8.2.36C A, B, C, D 1) A complete audit of all medications that we have have been checked against Doctors Orders and have been accounted for. 2) Administrator will make sure that all changes will have a current doctors order. If the changes are by phone, the Doctor will be required to fax a new Doctors Order immediately for our files. 3) In the event of a new doctors order the MAR will be Audited to reflect the current Physicians order. The old doctors order will be Discontinued and a New and complete doctors Order will be enter on the MAR with the current order. 4) All current medications have a doctors order. All entries on the MAR reflect the doctors orders. This was completed by December 20, 2007	

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A36	Continued From page 16 [redacted] Based on record review and interview, the facility failed to document the Medication Administration Record (MAR) with the following information: staff initials, name and initials of all staff administering medication for 4 of 4 sampled residents (100%). The findings are: A. Review of R1's 11/07 MAR revealed no authenticating signatures of the staff initialing the document. Additionally, R1's Controlled Substances Log noted that R1 had 55 tablets of hydrocodone remaining. However, a count of the hydrocodone tablets revealed an actual count of 54 tablets. B. Review of R2's 11/07 MAR revealed no authenticating signatures of the staff initialing the document. C. Review of R3's 11/07 MAR revealed no authenticating signatures of the staff initialing the document. Additionally, R3's MAR revealed that omeprazole was entered twice and was initialed by different staff as given twice per shift (double the prescribed dosage in the physician's order) from 11/6/07 - 11/9/07. D. Review of R4's 11/07 MAR revealed no authenticating signatures of the staff initialing the document. Additionally, R4's Controlled Substances Log noted that R4 was last given Ambien on 10/31/07 and there were 15 tablets remaining. However, a count of the Ambien tablets revealed an actual count of 13 tablets. E. During an interview with S11/Co-owner on 11/13/07 at 2:30 p.m., S11/Co-Owner	A36	7.8.2.36F (8,10) A, B, C, D, E 1) The facility has created a Controlled Substances Log that has to be filled out upon each change of shift. At the change of shift the employees must jointly count and sign the controlled substance log. If there is a discrepancy in the count, both employees must contact the Administrator immediately. An investigation will be done to find the problem at that time. All documentations will be entered on the MAR explaining the problem and what was done. Physician will be called if necessary to report missing medication. 2) An Audit has been done and all medication have been accounted for. 3) Each employee is responsible for all controlled substances during their shift. 4) Administrator will audit the controlled medication and log regularly to make sure all medications are accounted for. 5) All controlled substances medication have been Audited and a log created. The log and medications will be monitored by the administrator regularly. All medication have been accounted for. A Policy was put in to place on how to handle all controlled substance medications and reporting errors on December 20, 2007	

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A36	Continued From page 17 acknowledged that the facility failed to document R1-R4's 11/07 MAR's with the authenticating signature of staff initialing the documents. Additionally, S11/Co-Owner acknowledged that the count of R1's hydrocodone and R4's Ambien noted on their respective Controlled Substances Logs did not agree with the actual count of these medications. Further S11/Co-Owner acknowledged that omeprazole was erroneously entered twice on R3's MAR and initialed by different staff as having been given twice per shift from 11/6/07 - 11/09/07. [redacted] 7.8.2.36G Based on observation and interview the facility failed to immediately give residents medications removed from the pharmacy container for 7 of 7 total residents (100%). The findings are: A. Observation of the facility's kitchen/dining area on 11/13/07 at 8:00 a.m., revealed 6 residents eating breakfast at the dining table, 1 resident eating breakfast at the kitchen counter, and 7 small cups filled with pills on top of the kitchen counter within reach of the resident seated there. B. Observation of the facility's kitchen/dining area on 11/13/07 at 8:15 a.m. revealed 1 resident eating breakfast at the dining table, 1 resident eating breakfast at the kitchen counter with periodic staff assistance, and 1 small cup filled with pills on top of the kitchen counter within reach of the resident seated there. C. During an interview with S11/Co-Owner on 11/13/07 at 8:15 a.m., the surveyor asked if the pills were going to be given to the resident dining at the kitchen counter. S11/Co-Owner responded by motioning to the resident at the dining table	A36	A, B, C 1) All medication will be kept in the medication cabinet until it is ready to be poured. No medication will be poured until it is time to give to that resident. A sign has been put on the inside of the medication cabinet as a reminder to keep the cabinet locked at all times. 2) Keeping the medications locked and pouring at the time it is given, will prevent any error in medication. 3) Administrator will check regularly on how the employees are handling the medication to make sure they are appropriately following the proper procedures. 4) The new procedure was put in place on December 20, 2007 and will be on going.	

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A36	Continued From page 18 and stating, "the pills are for her when she finishes with breakfast. " [redacted] Based on records review and interview, the facility failed to report all medication errors to the physician for 3 of 4 sampled residents (75%). The findings are: A. Review of R1's Controlled Substances Log revealed that 55 tablets of hydrocodone were remaining. A physical count of the drug revealed 54 tablets remaining. B. Review of R3's 11/07 MAR revealed that omeprazole was entered twice and was initialed by different staff as given twice per shift (double the dosage ordered by the physician) from 11/6/07 - 11/9/07. C. Review of R4's Controlled Substances Log revealed that 15 tablets of Ambien were remaining. A physical count of the drug revealed 13 tablets remaining. D. During an interview with S11/Co-Owner on 11/13/07 at 2:30 p.m., S11/Co-Owner stated, "I should have reported the hydrocodone and Ambien errors to [R1 and R4's] physicians." Additionally, S11/Co-Owner acknowledged that omeprazole was erroneously entered twice on R3's MAR and initialed by different staff as having been given twice per shift from 11/6/07 - 11/09/07.	A36	7.8.2.361 A, B, C, D 1) Administrator typed up the procedures in reporting any and all medication errors. All medication errors have to be reported to the Administrator immediately and an investigation will be done immediately to try and resolve the problem. If it is needed the Physician will be notified of problem. All errors will be documented on the MAR and the actions taken to resolve the problem will be documented on the MAR. 2) The controlled substances log must be signed off by each shift and both employees agree on the count. Awareness on how important and critical errors are by having to report all errors to Administrator will ensure that the MAR is error free and all medications are accounted for. 3) Each shift change will have to report any and all errors to Administrator immediately. 4) A written policy has been put at the front of the MAR for reporting any and all discrepancies to Administrator. All controlled Substances and the log have been review and are appropriately reconciled and was completed on December 20, 2007.	
A37	7 NMAC 8.2.37 NUTRITION 7.8.2.37 NUTRITION: Each facility shall provide planned and nutritionally balanced meals	A37		

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A37	Continued From page 19 in accordance with the recommended daily dietary allowance from the basic food groups to 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	A37		

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A37	Continued From page 20 transmissible via food. F. Ensure the food is prepared by methods 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] [redacted] 7.8.2.37B A, B, C, D, E Based on records review, observation, and interview, the facility failed to post a copy of the current week ' s menu, failed to maintain menus as served for thirty days with substitutions recorded, and failed to ensure that identical menus were not recycled weekly. The findings are: A. Review of facility records revealed 4 undated typewritten weekly menus marked Week 1- Week 4 stored in a folder in the kitchen. Further review of the undated menus revealed that all the menus began on a Sunday and breakfast and lunch were identical for Week 1 and Week 2. B. Observation of the November 2007 calendar on 11/13/07 at 9:30 a.m. revealed that November	A37	1) A weekly menu has been posted making sure there are no duplications for a full month. Attached to the weekly menu are a list of daily snacks. 2) Administrator will make sure the menu is audited weekly making sure of no duplications. A full month of menus will be posted and audit weekly. 3) Administrator will check and audit the menu weekly. 4) The new menu was completed on December 20, 2007.	

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A37	Continued From page 21 1, 2007 began on a Thursday. C. During an interview with S11/Co-Owner on 11/13/07 at 8:30 a.m., S11/Co-Owner revealed that she "was following Week 4 of the menu." Since it was not Week 4 of the month, the surveyor asked S11/Co-Owner why she was following Week 4 of the menu. S11/Co-Owner stated, "We got a new supervisor and she changed the [menu] schedule." D. During an interview with S11/Co-Owner on 11/13/07 at 8:30 a.m., S11/Co-Owner revealed that she periodically made substitutions in the menu and recorded the substitutions elsewhere. When the surveyor asked for documentation of prior menus as served, with substitutions recorded, S11/Co-Owner indicated that she could not produce them. E. During an interview with the Administrator/Co-Owner on 11/13/07 at 3:20 p.m., the Administrator/Co-Owner reviewed the 4 undated weekly menus and acknowledged that breakfast and lunch were identical for Week 1 and Week 2.	A37		
A38	7 NMAC 8.2.38 FOOD MANAGEMENT 7.8.2.38 FOOD MANAGEMENT: Each facility must store, prepare, distribute and serve food under sanitary conditions and in accordance with the New Mexico Environment Department Food Service and Processor Regulations, if applicable. A. Each facility shall ensure a minimum of a three (3) day supply of perishable and a five (5) day supply of non-perishable or canned food is provided for the residents. B. All milk, to include dry milk products, shall be Grade A pasteurized.	A38		

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A38	Continued From page 22 C. Potentially hazardous food such as meat, milk, and custard shall be kept at 45 degrees F or below or at 140 degrees F or above. D. Each refrigerator and freezer shall be provided with an indicating thermometer accurate to plus or minus 3 degrees F, located in the warmest section of the refrigeration facility and must be of such type and so situated that the thermometer can be easily read. Thermostats shall not be relied upon to maintain temperatures at correct levels in the absence of thermometers. The temperature of the refrigerator shall be 35 degrees F- 45 degrees F. Freezer temperatures shall be maintained at 0 degrees F or below. E. Refrigerators, freezers, kitchen area and food preparation areas shall be kept clean and sanitary at all times. Food stored in refrigerators/freezers shall be covered, dated, and labeled. Unused leftover food shall be discarded after three days. F. Medication, biological, poisons, detergents, and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications may be stored in the refrigerator with food, if they are labeled and locked in a container marked specifically for medication. G. Dishes, utensils, and preparation equipment shall be properly washed and stored to maintain sanitary conditions. H. All garbage and rubbish shall be stored in containers which are waterproof, easily cleaned and have tight fitting lids. Food waste containers shall be kept in good repair, and shall be kept covered except during use. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 4-7-97; 7.8.2.38 NMAC - Rn, 7 NMAC 8.2.38, 8-31-00] [redacted] is not met as evidenced	A38		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5883	A. BUILDING _____ B. WING _____	11/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTS THAT CARE ASSISTED LIVING, LLC	9977 BUCKEYE STREET NW ALBUQUERQUE, NM 87114

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A38	Continued From page 23 [redacted] by: [redacted]	A38	7.8.2.38A A, B, C 1) Administrator will make sure that the facility has a minimum of 3 days of perishables and 5 days of non perishables or canned food in the facility at all times. Food on hand will be monitored on a daily basis. 2) Monitoring daily the food on hand will ensure proper amount of perishables and non-perishables are on hand. 3) Administrator will monitor the perishables and non-perishables daily to ensure that there are plenty of food available. 4) This process has been in place since December 20, 2007 and will be on going.	
	Based on observation and interview, the facility failed to ensure that a minimum of a three (3) day supply of perishable food was available for the current census of 7 residents. The findings are: A. Observation of the kitchen refrigerator contents on 11/13/07 at 9:30 a.m. revealed several condiments, 1 ½ loaves of bread, a pitcher of Kool-Aid, ½ gallon of milk, and little else. B. Observation of the garage refrigerator contents on 11/13/07 at 10:00 a.m. revealed few perishable items. C. During an interview with S11/Co-owner on 11/13/07 at 10:00 a.m., S11/Co-Owner stated, "the [seven] residents eat well and have plenty of food." S11/Co-Owner further stated, "we keep vegetables and bread in the freezer."			
	[redacted]		7.8.2.38D A, B, C, 1) A Thermometer has been purchased for all freezers and refrigerators and are in place. An extra Thermometer has been purchased for a back up if one gets broken or lost. A daily log has been attached to all refrigerators and freezers to reflect the readings will be done eve day. 2) The Thermometers will be checked daily to make sure the temperatures are at a correct level. A daily charting will be kept on all refrigerator and freezer. 3) The log will have the dates that the freezer and refrigerator levels ar to be written down. 4) This is in place and was completed by December 20, 2007 and will be on going.	
	Based on observation and interview, the facility failed to provide each refrigerator and freezer with an accurate indicating thermometer. The findings are: A. Observation of the facility's refrigerator/freezer located in the kitchen on 11/13/07 at 10:00 a.m. revealed no evidence of thermometers. B. Observation of the facility's refrigerator/freezer and free-standing freezer located in the garage on 11/13/07 at 10:30 a.m. revealed no evidence of thermometers.			

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A38	Continued From page 24 C. During an interview with the Administrator/Co-Owner on 11/13/07 at 3:20 p.m., the Administrator/Co-Owner acknowledged that the facility failed to provide each refrigerator and freezer with an accurate indicating thermometer. [redacted] Based on observation and interview, the facility failed to ensure that waste containers have tight fitting lids. The findings are: A. Observation of the facility's kitchen waste container on 11/13/07 at 9:30 a.m. revealed no evidence of a lid. B. During an interview with the Administrator/Co-Owner on 11/13/07 at 3:20 p.m., the Administrator/Co-Owner acknowledged that the facility failed to ensure that its kitchen waste container had a lid.	A38	7.8.2.38H A, B 1) A sign has been put on the lid of the trash can to remind employees that the lid must stay on the container at all times. 2) Will check regularly to make sure that the employees are keeping the lid on the trash can. 3) Will monitor throughout the day. 4) Sign was put on lid and will be monitored throughout the day. Completed on December 20, 2007 and will be on going.	
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 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	A41		

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A41	Continued From page 25 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 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	A41		

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A41	Continued From page 26 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 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	A41		

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A41	Continued From page 27 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 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] [redacted] Based on interview, the non-sprinkled facility failed to ensure that it maintained a "prompt"	A41		

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A41	Continued From page 28 evacuation capability rating by conducting individual Fire Safety Evaluation System (FSES) surveys on 7 of 7 total residents (100%), compiling the results, and determining the facility-wide evacuation capability. The findings are: A. Review of facility records revealed no evidence of resident FSES surveys or a facility evacuation rating. B. During an interview with S11/Co-Owner on 11/13/07 at 10:30 a.m., S11/Co-Owner revealed that she was unaware of the FSES requirements. C. During an interview with the Administrator/Co-Owner on 11/13/07 at 3:20 p.m., the Administrator/Co-Owner revealed that she was also unaware of the FSES requirements. The Administrator/Co-Owner acknowledged that the facility failed to ensure that it maintained a "prompt" evacuation capability rating.	A41	7.8.2.41A A, B, C. 1) A FSES survey was completed. An evacuation capability rating was rated at PROMPT. 2) Upon admittance of a new resident, a FSES will be completed to reflect the new facility evacuation rating. If a resident changes, a new FSES will be completed to reflect the new facility evacuation rating. 3) The FSES form has been added to the new resident's admit paper work. These ratings will be kept in the Fire Drill folder. 4) Administrator will follow up to make sure all the paper work is completed for all new residents and that the FSES form is completed and filed. All FSES form has been filled out for each resident. Was completed by January 1, 2008 and will be on going when there is a change.	
A62	7 NMAC 8.2.62 FIRE EXTINGUISHERS 7.8.2.62 FIRE EXTINGUISHERS: A. As approved by the State Fire Marshall or Fire Prevention Authority having jurisdiction must be located in the facility. Facilities must as a minimum have two (2) 2A10BC fire extinguishers, one (1) located in the kitchen or food preparation area, and one (1) centrally located in the facility. All fire extinguishers shall be inspected yearly and recharged as needed. All fire extinguishers must be tagged noting the date of inspection. B. Fire extinguishers, alarm systems, automatic detection equipment, and other fire fighting equipment must be properly maintained and inspected as recommended by the manufacturer, State Fire Marshall, or Fire	A62		

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A62	Continued From page 29 Authority having jurisdiction. [7-1-64, 9-24-76, 7-11-86, 4-7-97; 7.8.2.62 NMAC - Rn, 7 NMAC 8.2.62, 8-31-00] [redacted] is not met as evidenced by: 7.8.2.62A. Based on observation and interview, the facility failed to ensure that it had a minimum of two 2A10BC fire extinguishers, one located in the kitchen or food preparation area. The findings are: A. Observation of the facility's two fire extinguishers on 11/13/07 at 10:00 a.m. revealed that neither extinguisher was located in the kitchen or food preparation area. B. During an interview with the Administrator/Co-Owner on 11/13/07, at 3:20 p.m., the Administrator/Co-Owner acknowledged that the facility failed to ensure that one fire extinguisher was located in the kitchen or food preparation area.	A62	7.8.2.62A A, B 1) All Fire Extinguishers have been moved to the proper locations. One Extinguisher was put in the kitchen and there is another one in the hall going to the back bed rooms. We had the Fire Marshall help us in the proper placement of the Extinguishers. 2) The Fire Marshall recently checked the Fire Extinguishers and help in relocating the Extinguishers. 3) Fire Extinguisher were relocated to the kitchen and the hall. 4) Completed on December 20, 2007.	
A63	7 NMAC 8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING 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	A63		

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A63	Continued From page 30	A63		

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 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]

[redacted] is not met as evidenced [redacted]

Based on records review and interview, the facility failed to conduct at least one fire drill each

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A63	Continued From page 31 month. The findings are: A. Review of fire drill records revealed no evidence that the fire alarm/detector system was used during the drills and no evidence that the residents were evacuated from the facility. B. During an interview with S11/Co-Owner on 11/13/07 at 10:00 a.m., S11/Co-Owner revealed that the facility conducted "mock fire drills, did not use the fire alarm, and did not actually evacuate any of the residents because the fire department told us we didn't have to." C. During an interview with S11 and the Administrator (co-owners) on 11/13/07 at 3:20 p.m., both parties acknowledged that the facility failed to conduct actual fire drills each month, failed to use the fire alarm/detector during the drills, and failed to evacuate any of the residents.	A63	7.8.2.63D (1-4) A, B, C, 1) Administrator will monitor fire drills monthly to make sure it is done by regulations. The fire alarms will be used during the fire drill. 2) Administrator will make sure this is done monthly. 3) Administrator will participate in the fire drill monthly. 4) A fire drill form has been created with evacuation time, date, place of the drill , number of personnel participated in the drill and any problems noted during the drill. The total time it took to evacuate will be noted on the form and a place to check whether the fire alarm was used. A complete fire drill will be completed by January 9, 2007. A file has been set up in the facility for fire drills.	
A66	7 NMAC 8.2.66 RELATED REGULATIONS AND CODES 7.8.2.66 RELATED REGULATIONS AND CODES: Adult residential care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96). B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96). C. Adjudicatory Hearings, New Mexico Department of Health, 7 NMAC 1.2 (2-1-96). [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.66 NMAC - Rn, 7 NMAC 8.2.66, 8-31-00] This REQUIREMENT is not met as evidenced	A66		

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A66	Continued From page 32 by: [redacted] Based on record review and interview, the facility failed to maintain records of pre-employment Employee Abuse Registry (EAR) inquiries for 1 of 1 sampled non-licensed/non-certified staff hired as of 1/1/06 (effective date of rule). The findings are: A. Review of S12's personnel records revealed a hire date of 6/2/07. S12's records revealed no evidence that the facility conducted a pre-employment EAR inquiry. B. During an interview with the Administrator/Co-Owner on 11/13/07 at 3:20 p.m., the Administrator/Co-Owner acknowledged that the facility failed to maintain records of pre-employment EAR inquiries on S12.	A66	7.8.2.66: 7.1.12 (Employee Abuse Registry) 1) Administrator will make sure the registry is checked before hiring a new employee. 2) Administrator will make sure that before a new employee is hired that the EAR is checked first and is clear. 3) The new hire paperwork check list will have the EAR added and a place to put clear or not clear. An attached report will be put in the employees file. 4) All employees will have the EAR put in their file by January 11, 2008. All new employees will have a EAR in their file before they are hired.	