PRINTED: 06/09/2016
FORM APPROVED

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5686	A. BUILDING: ______ B. WING ______	C 12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT ASSISTED LIVING (THE)	**2969 CLAUDE DOVE DRIVE LAS CRUCES, NM 88011**

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A 000	Initial Comments On-site/Monitoring survey were completed on 12/03/15 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Deficiencies were cited as result of the On-site/Monitoring survey.	A 000		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13	A 020		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marilyn J Johnson

TITLE: Director

(X6) DATE: 6/16/16

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A 020	Continued From page 1 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit.	A 020		

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A 020	Continued From page 2 Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. 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 remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to	A 020		

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A 020	Continued From page 3 remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20	A 020		

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A 020	Continued From page 4 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.20 D. (1) Based on record review and interview the facility failed to have evidence of Care Coordination on the Individual Service Plan (ISP) for 1 (R #1) of 2 (R #s 1 and 5) residents reviewed for Home Health Services. This deficient practice could lead to Caregivers not knowing what services the Home Health Agency is providing and not be able to coordinate such services. The findings are: A. Record review of the chart for R #1 revealed there was nothing on the ISP for the services being provided by the Home Health Agency. B. On 11/25/15 at 1:20 pm, in an interview with the facility nurse, she confirmed there was nothing on the ISP for R #1 to show Care Coordination with the Home Health Agency.	A 020	**A 020 NMAC 7.8.2.20D(1) ADMISSIONS AND DISCHARGE** **All Home Health and/or Hospice entities that are involved with residents at The Aristocrat Assisted Living will be included on the individual resident's ISP and said entities will be included in all Individual Service Plan meetings. When Home Health and/or Hospice entities are started initially, they will be immediately included on the resident's ISP.** **QA review will be conducted by outside consultant for three (3) months to assure that all Home Health and/or Hospice entities in The Aristocrat are correctly documented.** **Responsible: Clinical Manager with oversight by Director and QA for three (3) months.**	12/5/15 6/15/16
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday.	A 032		

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A 032	Continued From page 5 (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to report to the Licensing Authority for 2 (R #s 1 and 5) of 5 (R #s 1, 2, 3, 4 and 5) residents that had reportable incidents of the following: 1.) injury to a resident of unknown origin; and 2.) a missing sound bar (speaker) belonging to a resident. This deficient practice has the potential for physical abuse of a resident and exploitation of a resident to continue by not being reported to and investigated by the Licensing Authority. The findings are: A. Record review of a facility incident report	A 032	**A 032 7NMAC 8.2.32 REPORTING OF INCIDENTS** **All incidents regarding possible abuse, neglect, exploitation, injuries of an unknown origin or other reportable incidents be completed within 24 hours of said incident or the next business day if the incident occurs on a weekend or holiday.** **All incidents that require investigation will be completed and such information will be forwarded as a follow up within five days and plans for further actions in response to the incident will be included.** **QA review will be conducted for three (3) months of all State reportable incident reports and non-reportable incident reports to assure that documentation and reporting is correct.** **Responsible: Clinical Manager with oversight by Director and QA for three (3) months.**	12/5/15 6/15/16

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A 032	Continued From page 6 revealed an internal incident report dated 07/31/15 documenting that R #1 was found with a 4 centimeter diameter hematoma to her right forehead with origin noted as unknown. There was no Incident Report Form on the incident and no evidence the Licensing Authority was notified of the incident. B. On 09/23/15 at 9:46 am, the administrator and the facility nurse confirmed there was no report sent to the Licensing Authority about the injury of unknown origin to R #1. The facility nurse further acknowledged R #1 is unable to tell anyone what has happened about anything. C. On/12/01/15 at 9:10 am, the administrator acknowledged that a sound bar (speaker) valued around $40.00 had disappeared from the room of R #5 and she confirmed there was no report sent to the Licensing Authority.	A 032		
A 043	7 NMAC 8.2.43 Hazardous Areas HAZARDOUS AREAS: Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than one hundred (100) sq. ft., storage rooms more than fifty (50) sq. ft. but less than one hundred (100) sq. ft. not storing combustibles, storage rooms with more than one hundred (100) sq. ft. storing combustibles, chemical storage rooms with more than fifty (50) sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either: (1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter (3/4)	A 043		

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A 043	Continued From page 7 hour rating; or (2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or (3) other hazardous areas shall be enclosed with walls with at least a twenty (20) minute fire rating and doors equivalent to one and three-quarter (1 3/4) inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. Boiler, furnace or fuel fired water heater rooms. For facilities with four (4) or more residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one (1) hour. Doors to these rooms shall be one and three-quarter (1-3/4) inch solid core. [7.8.2.43 NMAC - Rp, 7.8.2.44 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.43 B. Based on observation and interview, the facility failed to ensure that penetrations and holes in a hazardous area (water heater room) in four (4) fire rated walls and ceilings were properly sealed with approved fire suppression material. This deficient practice presents a risk to all 32 residents identified on the Resident Census List provided by the Administrator on 09/30/15 and all occupants of the building from smoke and fire passing through the fire rated wall in the event of a fire. The findings are:	A 043	**A 043 7NMAC 8.2.43 HAZARDOUS AREAS** **All room, resident and auxiliary rooms, such as the water heater room, will be inspected on a monthly basis for penetrations and/or holes. If any penetra-tions and/or holes are noted they will be corrected within 24 hours.** **Monthly check off form will be prepared for inspection of same and will be signed and dated by person making inspection.** **Responsible: Director and Maintenance Department.** **Water Heater room corrected** **Inspection form completed**	 12/5/15 6/15/16

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A 043	Continued From page 8 A. On 12/02/15 at 10:00 am, during a tour of the facility with the Head of Maintenance, it was observed that there were several penetrations and holes through the walls and ceiling of the fuel fired water heater room that were not sealed. B. On 12/02/15 at 10:00 am, in an interview with the Head of Maintenance while touring the facility, he confirmed that there were several penetrations and holes through the walls and ceiling of the fuel fired water heater room that were not sealed.	A 043		
A 062	7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Facilities with nine (9) or more residents shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. [7.8.2.62 NMAC - Rp, 7.8.2.61 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to protect the health and safety of the facility's 32 (R #1 - 32) residents on the list provided by the Administrator on 11/20/15 by: 1.) not installing Automatic Fire Protection Sprinklers in resident room closets; 2.) not installing Automatic Fire Protection Sprinklers in one resident bathroom; 3.) not maintaining escutcheons (cover that seals the penetration in the ceiling around the sprinkler) on Automatic Fire Protection Sprinklers	A 062		

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A 062	Continued From page 9 throughout the building; and 4.) not maintaining an Automatic Fire Protection Sprinkler in the closet of a resident room. This deficient practice has the potential in case of a fire in these areas to allow fire and smoke to spread rapidly endangering all residents, staff, and visitors in the facility. The findings are: A. On 12/02/15 at 10:00 am, during a tour of the facility with the Administrator, the closets in resident rooms 6, 14, 23, 36, and the bathroom in resident room 23 did not have Automatic Fire Protection Sprinklers. The Automatic Fire Protection Sprinklers in resident closets 8, 9, 18, and 23, resident bathroom 12, and resident rooms 14, 18, 22, 23, and 27 either were missing an escutcheon or had the escutcheon dropped down around the Automatic Fire Protection Sprinklers leaving the penetration through the ceiling not sealed. The Automatic Fire Protection Sprinkler in resident closet 12 was covered with dried wall compound. B. On 12/02/15 at 10:00 am, in an interview with the administrator during the tour of the facility, she confirmed the closets in resident rooms 6, 14, 23, 36, and the bathroom in resident room 23 did not have Automatic Fire Protection Sprinklers. She further confirmed the Automatic Fire Protection Sprinklers in resident closets 8, 9, 18, and 23, resident bathroom 12, and resident rooms 14, 18, 22, 23, and 27 either were missing an escutcheon or had the escutcheon dropped down around the Automatic Fire Protection Sprinklers leaving the penetration through the ceiling not sealed and the Automatic Fire Protection Sprinkler in resident closet 12 was covered with dried wall compound.	A 062	**A 062 7NMAC 8.2.62 AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM** **All fire protection escutcheons will be inspected on a monthly basis to assure that they are properly installed and maintained. If any corrections are noted, they will be corrected within 24 hours.** **Monthly check off form will be prepared for inspection of same and will be signed and dated by person making inspection.** **Responsible: Director and Maintenance Department.** **All escutcheons repaired and/or replaced** **All closet and bathroom sprinklers noted were installed by Dimar Systems LLC** **Inspection form completed**	 12/4/15 3/3/16 6/15/16

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A 070	Continued From page 10	A 070		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor ' s order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation.	A 070		

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A 070	Continued From page 11 B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview the facility failed to report to the Licensing Authority for 2 (R #s 1 and 5) of 5 (R #s 1, 2, 3, 4 and 5)residents that had reportable incidents of the following: 1.) injury to a resident of unknown origin; and 2.) a missing sound bar (speaker) belonging to a resident. This deficient practice has the potential for physical abuse of a resident and exploitation of a resident to continue by not being reported to and investigated by the Licensing Authority. The findings are: A. Record review of a facility incident reports revealed and internal incident report dated 07/31/15 documenting that R #1 was found with a 4 centimeter diameter hematoma to her right forehead with origin noted as unknown. There was no Incident Report Form on the incident and	A 070	**A 070 7NMAC 7.1.13.7 W. & 8 B. (2) REPORTING OF INCIDENTS** **All incidents regarding possible abuse, neglect, exploitation, injuries of an unknown origin or other reportable incidents be completed within 24 hours of said incident or the next business day if the incident occurs on a weekend or holiday.** **All incidents that require investigation will be completed and such information will be forwarded as a follow up within five days and plans for further actions in response to the incident will be included.** **QA review will be conducted for three (3) months of all State reportable incident reports and non-reportable incident reports to assure that documentation and reporting is correct.** **Responsible: Clinical Manager with oversight by Director and QA for three (3) months.**	12/5/15 6/16/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5686	A. BUILDING: ______ B. WING ______	C 12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 070	Continued From page 12 no evidence the Licensing Authority was notified of the incident. B. On 09/23/15 at 9:46 am, the administrator and the facility nurse confirmed there was no report sent to the Licensing Authority about the injury of unknown origin to R #1. The facility nurse further acknowledged R #1 is unable to tell anyone what has happened about anything. C. On/12/01/15 at 9:10 am, the administrator acknowledged that a sound bar (speaker) valued aroung $40.00 had disappeared from the room of R #5 and she confirmed there was no report sent to the Licensing Authority.	A 070		