STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Full-Onsite/Complaint survey completed on 04/05/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint intake #30432 was unsubstantiated with deficiencies cited.	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC.	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 1 B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010]	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 2 This REQUIREMENT is not met as evidenced by: 7.8.2.16 A (4) B (3) Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 3	A 016		

employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry.
D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.
E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.
F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 4	A 016		

not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.
[7.1.12.8 NMAC - N, 01/01/2006]

Based on record review and interview the facility failed to ensure that the Direct Care Staff (DCS) had been cleared by the Employee Abuse Registry (EAR) prior-to-hire. This deficient practice could affect the safety and welfare of all 45 (1-45) residents listed on the census provided by the Administrator on 04/03/19 if being provided care by DCS who may have a previous history of abusing, neglecting, or exploiting residents and/or is a convicted felon. The findings are:

Findings related to staff files

A. Record review of the staff files for:
1. DCS #1 (hire date 08/01/04) revealed, that the EAR was not submitted until 08/30/06.
2. DCS #2 (hire date 01/08/19) revealed, that the EAR was not submitted until 03/27/19.
3. DCS #3 (hire date 09/08/17) revealed, that the EAR was not submitted until 10/16/17.

B. On 04/03/19 at 1:05 pm, during an interview with the Administrator, she confirmed that the Employee Abuse Registry (EAR) were not submitted or clearances received prior-to-hire for DCS #s 1-3.

Findings related to Administrator.

C. Record review of the Administrator's staff file revealed no documentation of completion of a state approved certification program for assisted living administrators.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 5 D. On 04/03/19 at 9:50 am, during an interview with the Administrator, she confirmed that she had not completed a state approved assisted living administrators certification program.	A 016		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with	A 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 017	Continued From page 6	A 017		

medication delivery; and
(12) the proper way to implement a resident ISP for staff that assist with ISPs.
D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation.
[7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.17 A B C

Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS) received 16 hours of supervised training prior to providing unsupervised care; 12 hours of orientation and/or annual training required by regulation, and that documentation of completed trainings was kept at the facility.

This deficient practice has the potential for the 45 (R #s 1-45) residents listed on the census provided by the Administrator on 04/03/19, to be at a higher risk of physical or mental harm if the DCS cannot provide the care and services needed, because they have not completed the required trainings. The findings are:

A. Record review of the DCS #s 1-3 training files revealed, no documentation of:
1. Receiving 16 hours of supervised training prior to providing unsupervised care.
2. Receiving 12 hours of orientation and or yearly annual training required by regulation.

B. On 04/03/19 at 12:58 pm, during an interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 017	Continued From page 7 with the Administrator, she confirmed that the DCS #s 1-3 had not completed the required trainings listed above and that there is no documentation of training in DCS files.	A 017		
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 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the	A 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 8	A 020		

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. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following:
(1) ventilator dependency;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 9 (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 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 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 10 (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 NMAC, 01/15/2010]	A 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 11	A 020		

This REQUIREMENT is not met as evidenced by:
7.8.2.20 A (2-3, 5-12) (a-e) (i-iii) D

Refer to Senate Bill (SB) 0335 - 2013

AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Public Health Act is enacted to read:

"ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.--

A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings.

B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 12	A 020		

storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them.

C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health."

SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

Based on record review and interview, the facility failed to ensure for 3 (R #'s 3-5) of 3 (R #'s 3-5) residents whose Admission Agreements were reviewed for compliance that they:

1. Were accurate and included all required information.
2. Included a refund upon death policy that was in compliance with 7 NMAC 7.8.2.20 and Senate Bill (SB) 0335 - 2013.
3. The Individual Service Plans (ISP's) included coordination of care for all services provided in the facility by outside health care providers.

These deficient practices have the potential for all residents to be at risk of:

1. Not receiving the proper services due to missing and incorrect information on their Admission Agreement.
2. The resident's estate to not be aware of due to the residents estate or charges that can accrue to the facility after the resident's death.
3. Residents not receiving the higher level of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 13	A 020		

care and services needed, because the Direct Care Staff (DCS) do not know what services they are to provide and what services the Home Health agency will provide.

The findings are:

A. Record Review of R #s 3-5's Admission Agreements revealed that they did not include:
1. A refund upon death policy that was in compliance with the Regulations for Assisted Living Facilities NMAC 7.8.2.20 and Senate Bill (SB) 0335 - 2013.
2. Facility's rules.
3. Information to formulate advance directives.
4. Notification of rights and responsibilities (pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC).
5. The Admission agreement may be terminated by the facility if an appropriate placement is found.

B. Record review of R #3's Admission Agreement (dated 02/28/19) revealed, that the following information was not included:
1. Program narrative.
2. Written description of residents legal rights.
3. The facility's staffing ratio.
4. Written authorization for staff to assist with medications.
5. Bed hold policy.

C. Record Review of R #s 3 and 5 residents files revealed no ISP's available for review.

D. On 04/04/19 at 2:37 pm, during an interview with the Administrator, she confirmed that the Admission Agreements for R #s 3-5 were missing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 14 the above listed information. She also confirmed that there were no ISP's available for review for R #s 3 and 5 who were receiving hospice services.	A 020		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph;	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 021	Continued From page 15 (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) 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; (7) entries by direct care staff, appropriate health care professionals and 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 ISP; (8) entries that provide 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 documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 021	Continued From page 16 information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 021	Continued From page 17 7.8.2.21 A (1-2, 5) (c-o, q) Based on record review and interview the facility failed to ensure for 3 (R #s 3-5) of 3 (R #s 3-5) resident files reviewed for compliance included the following resident information: 1. The complete admission agreement records as set forth in 7.8.2.20 NMAC. 2. Resident Evaluations. 3. All required demographic information This deficient practice has the potential for all residents to be at risk of harm and not receive the care/services needed if: 1. The Admissions Agreement does not include all required information. 2. Evaluations are not completed and the Direct Care Staff (DCS) do not know what needs and services are needed. 3. Personal and demographic information is not readily available for DCS staff to review when needed. The findings are: A. Record review of R #3's resident file revealed, the following information was missing from the chart: 1. The complete admission agreement records as set forth in 7.8.2.20 NMAC 2. The resident evaluation. 3. Personal and demographic information. B. Record review of R #4's resident file revealed the following information was not included in the chart: 1. The complete admission agreement records as set forth in 7.8.2.20 NMAC 2. The resident evaluation. 3. All required personal and demographic information.	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 021	Continued From page 18 C. Record review of R #5's resident file revealed, the following information was not included in the chart: 1. The complete admission agreement records as set forth in 7.8.2.20 NMAC. 2. All required personal and demographic information. D. On 04/04/19 at 2:37 pm, during interview with the Administrator, she confirmed the findings listed above for R#s 3-5.	A 021		
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food	A 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 022	Continued From page 19	A 022		

management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained;
(7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction;
(8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks;
(9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSES) rating, if applicable;
(10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of emergencies:
(a) an emergency that affects just the facility; and
(b) a region/area wide emergency;
(11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC);
(12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and
(13) vaccination records for pets in the facility.
B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 022	Continued From page 20 available for review upon request by the licensing authority: (1) a copy of the facility license; (2) employee personnel records, including an application for employment, training records and personnel actions: (a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC; (b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and (3) a copy of all waivers or variances granted by the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas; (7) accommodation of resident ' s pets; and (8) resident use of electric blankets and appliances. D. 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; (2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission;	A 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 022	Continued From page 21 (3) policy for medication errors; (4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.); (5) the handling of resident's funds, if the facility provides such services; (6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (12) admission agreement; (13) admission records; (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents;	A 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 022	Continued From page 22 (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (10) (a-b) Based on record review and interview, the facility failed to ensure that there were written emergency evacuation plans for both facility only and community wide disasters. This deficient practice has the potential for all 45 (R #s 1-45) residents listed on the census provided by the House Manager on 04/03/19 to be at risk of harm, injury, illness and/or death if a facility or community wide disaster occurred and the residents were unable to be safely evacuated from the facility or community. The findings are: A. Record request for the emergency evacuation plan for facility disasters revealed no documentation that the facility had a plan in place. B. Record request for the emergency evacuation plan for community wide disasters revealed no documentation that the facility had a plan in place. C. On 04/03/19 at 3:50 pm, during an interview	A 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 022	Continued From page 23 with the Administrator, she confirmed that the facility does not have emergency evacuation plans for disasters or emergencies that affect the facility or the community.	A 022		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to 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) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 026	Continued From page 24	A 026		

require with activities of daily living and with medications;
(10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and
(11) current orders for all medications, including those authorized for PRN usage.
[7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.26 A B (1 & 9)

Based on record review and interview the facility failed to ensure for 3 (R #s 3-5) of 3 (R #s 3-5) residents whose resident files were reviewed for compliance:
1. Included an Individual Service Plan (ISP).
2. Addressed and included documentation of all services to be provided based on the evaluation and through staff observations.
3. The level of assistance with medications required by the resident.

This deficient practice has the potential for all residents to be at risk of harm, injury, illness and/or death if a facility is unaware of their individual needs, the services to be provided by the facility or by other agencies, and changes of condition. The findings are:

A. Record review of R #s 3 and 4 resident files revealed no ISPs available for review.

B. Record review of R #5's ISP (dated March 2019) revealed, it did not address or include:
1. A written description of all services to be provided based on the evaluation and through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 026	Continued From page 25 staff observations. 2. The level of assistance with medications required by the resident. C. On 04/04/19 at 2:37 pm, during an interview with the Administrator, she confirmed the ISP findings for R #s 3-5.	A 026		
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. (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	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 26 incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) B Refer to 7.1.13.7 W. & 8 B. (2) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS 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. 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	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 27	A 032		

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 ensure that for 1 (R #10) of 1 (R #10) resident who made multiple allegations of [redacted] by [redacted] doctor, a male resident, and several female Direct Care Staff (DCS) that:

1. The incidents were reported to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend.
2. Follow-up investigation reports were submitted within five (5) business days after the incident.

This deficient practice has the potential for all residents to be at risk of being abused, neglected, and/or not receiving needed medical care and services if:

1. Incidents of alleged abuse are not being reported to the Licensing Authority within the required time.
2. The facility is not conducting internal investigations and submitting their findings to the Licensing Authority. The findings are:

A. Record review of Department of Health complaint intake NM#30432 revealed that R #10 made an allegation of sexual abuse by a Direct Care Staff (DCS).

B. On 04/04/19 at 8:45 am, during an interview with the Administrator, she stated that R #10 had made multiple accusations while [redacted] was at the facility including:

[redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 28	A 032		

[redacted]

C. Record review of the facility Incident reports for 2017 and 2018 revealed no documentation of R #10's multiple allegations of sexual assault by

[redacted]

D. On [redacted]/19 at 11:45 am, during an interview with the Administrator, she confirmed that they facility had not:

[redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 047	7 NMAC 8.2.47 Lighting and Lighting Fixtures LIGHTING AND LIGHTING FIXTURES: A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area clearly visible. B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting. C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the residents, with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering. E. Facilities with four (4) or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service. F. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7.8.2.47 NMAC - Rp, 7.8.2.48 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.47 E Refer to: NFPA (National Fire Prevention Association) 101, 2012 Edition 7.9.3 Periodic Testing of Emergency Lighting Equipment.	A 047		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 047	Continued From page 30 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 11/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator. (4) A visual inspection shall be performed at intervals not exceeding 30 days. (5) Functional testing shall be conducted annually	A 047		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 047	Continued From page 31	A 047		

for a minimum of 11/2 hours.
(6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 11/2-hour test.
(7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.

7.10.9 Testing and Maintenance.
7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days or shall be periodically monitored in accordance with 7.9.3.1.3.
7.10.9.2 Testing. Exit signs connected to, or provided with, a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3.

Based on observation and interview, the facility failed to ensure that there was emergency lighting that activates automatically to light the exterior exit passageways. This deficient practice has the potential for all 45 (R #s 1-45) residents identified on the census provided by the Administrator 04/03/19, to be at risk of harm, injury, and/or death if there they are unable to see to evacuate the building due to not having emergency lighting, if a fire or other emergency that requires evacuation occurs. The findings are:

A. On 04/09/19 at 9:45 am, during observation of the exterior exit passageways there was no lighting observed to light the exterior emergency evacuation pathways from the building.

B. On 04/09/19 at 10:10 am, during an interview with the Owner (and his daughter) he confirmed that there were no lights to light the exterior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 047	Continued From page 32 emergency evacuation pathways.	A 047		
A 055	7 NMAC 8.2.55 Toilet and Bathing Facilites TOILET AND BATHING FACILITIES: Toilet and bathing facilities shall be located appropriately to meet the needs of residents. A. A minimum of one (1) toilet, one (1) sink and one (1) bathing unit shall be provided for every eight (8) residents or fraction there of. (1) The facility shall provide at least one tub and one shower or combination unit to allow for residents bathing preference. (2) Facilities with four (4) or more residents shall provide a handicap accessible bathroom for every thirty (30) residents that allows for a bathing preference. B. Facilities with four (4) or more residents must comply with accessibility requirements for the disabled. C. Toilet, sink and bathing facilities shall be readily available to the residents. No passage through a resident room by another resident to reach a toilet, bathing unit or sink facility shall be permitted. D. The combination type tub and shower shall be permitted. E. A facility with four (4) or more residents that has live-in staff shall provide a separate toilet, sink and bathing facility for staff. F. Toilets, tubs and showers shall be provided with grab bars. G. Tubs and showers shall have a slip resistant surface. H. The floors of bathrooms and bathing facilities shall have smooth, waterproof and slip-resistant surfaces. I. Toilet paper and soap shall be provided in each toilet room.	A 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 055	Continued From page 33 J. The use of a common towel shall be prohibited. K. Bathrooms and lavatories shall be cleaned as often as necessary to maintain a clean and sanitary condition. [7.8.2.55 NMAC - Rp, 7.8.2.56 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.55 A (1) Based on observation and interview, the facility failed to ensure the facility provided at least one tub to allow for residents a bathing preference. This deficit practice has the potential for all 45 (R #s 1-45) residents identified on the census provided by the Administrator on 04/03/19, to not have a bathing preference (bath or shower). The findings are: A. On 04/09/19 at 10:40 am, during observation with the Owner, it was observed that there was no bathtub in the facility. B. On 04/09/19 at 10:42 am, during an interview with the Owner, he confirmed that there were no bathtubs in the facility.	A 055		
A 066	7 NMAC 8.2.66 Staff and Resident Fire and Safety Training STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff of the facility shall know the location and the proper use of fire extinguishers and the other procedures to be followed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic	A 066		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 066	Continued From page 34 instructions in the use of fire prevention and techniques of evacuation. B. Facility staff shall be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident admitted to the facility shall be given an orientation tour of the facility to include the location of the exits, fire extinguishers and telephones and shall be instructed in the actions to be taken in case of fire or other emergencies. D. Fire drill procedures. The facility must conduct at least one (1) fire drill each month. (1) Fire drills shall be held at different times of the day, evening and night. (2) The fire alarm system or detector system in the facility shall be used in the fire drills. During the night, the fire drill alarm may be silenced. (3) During the fire drills, emphasis shall be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall show the date and time of the drill, the number of personnel participating in the drill, any problem(s) noted during the drill and the evacuation time in total minutes. (5) The local fire department may be requested to supervise and participate in the fire drills. [7.8.2.66 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 066		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 066	Continued From page 35 7.8.2.66 A C Based on record review and interview, the facility failed to ensure that: 1. The Direct Care Staff (DCS) received Fire Safety and Evacuation Training at orientation and annually. 2. Upon admission, all residents/family members received Fire Safety and Evacuation Training that included a tour of the facility, the location of the exits, fire extinguishers, and telephones, and were instructed in the actions need to be taken in case of fire or other emergencies that require evacuation. These deficient practices have the potential for all 45 (R #s 1-45) residents listed on the census provided by the Administrator on 04/03/19, DCS, and all occupants to be at risk of harm, injury, illness and/or death if a fire or other emergency requiring evacuation were to occur and DCS and residents did not know how to evacuate safely. The findings are: Findings related to DCS training A. Record review of the staff files for DCS #s 1-3 revealed no documentation of receiving training in Fire Safety and Evacuation at orientation and/or annually. B. Record review R #s 3-4, and 6 revealed no documentation of residents/family members receiving training in Fire Safety and Evacuation upon admission. C. On 04/03//19 at 12:58 pm, during an interview with the Administrator, she confirmed that: 1. DCS #s 1-3 staff files revealed no documentation of receiving Fire Safety and	A 066		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 066	Continued From page 36 Evacuation training at orientation and/or annually. 2. R #s 3-4, and 6 resident files containing no documentation of the residents/family members receiving training in Fire Safety and Evacuation upon admission. 3. No trainings were conducted for the DCS or residents/families.	A 066		
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: 7.8.2.70 E F Refer to 7.1.12 EMPLOYEE ABUSE	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 37 REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 38	A 070		

information required by the registry.
D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.
E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.
F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.

[7.1.12.8 NMAC - N, 01/01/2006]
7.1.13 INCIDENT REPORTING, INTAKE,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 39 PROCESSING AND TRAINING REQUIREMENTS 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. 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 ensure that: 1. Direct Care Staff (DCS) had been cleared by the Employee Abuse Registry (EAR) prior to hire. 2. Incidents of allegations of abuse were reported to the Licensing Authority within 24	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 40	A 070		

hours or the next business day if a holiday or weekend.

3. That the facility conducted internal investigations and that follow-up investigation reports were submitted to the Licensing Authority within 5 business days from the date of the incident occurred.

This deficient practice could affect the safety and welfare of all 45 (1-45) residents listed on the census provided by the Administrator on 04/03/19 if:

1. Care is being provided by DCS who may have a previous history of abusing, neglecting, or exploiting residents.

2. There is no oversight by the Licensing Authority, if incidents of alleged abuse are not being reported.

3. The facility does not conduct internal investigations and submitting follow up investigation reports within 5 business days after the incident. The findings are:

Findings related to EARs:

A. Record review of the staff files for:

1. DCS #1 (hire date 08/01/04) revealed, that the EAR was not submitted until 08/30/06.

2. DCS #2 (hire date 01/08/19) revealed, that the EAR was not submitted until 03/27/19.

3. DCS #3 (hire date 09/08/17) revealed, that the EAR was not submitted until 10/16/17.

B. On 04/03/19 at 1:05 pm, during an interview with the Administrator, she confirmed that the Employee Abuse Registry (EAR) were not submitted or clearances received prior-to-hire for DCS #s 1-3.

Findings related to incident reports:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 41 C. Record review of Department of Health complaint intake NM#30432 revealed that R #10 made an allegation of sexual abuse by a Direct Care Staff (DCS). D. On 04/04/19 at 8:45 am, during an interview with the Administrator, she stated that R #10 had made multiple accusations while [redacted] was at the facility including: [redacted] E. Record review of the facility Incident reports for 2017 and 2018 revealed no documentation of R #10's multiple allegations of [redacted] by [redacted]	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5647	A. BUILDING: _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE LIVING	**10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 42 [redacted] F. On 04/04/19 at 11:45 am, during an interview with the Administrator, she confirmed that they facility had not: 1. Reported R #10's allegations of sexual abuse to the Licensing Authority within 24 hours or the next business day if a holiday or weekend. 2. Conducted internal investigation or submitted the follow-up investigation reports to the Licensing Authority within 5 business days after any of the alleged incidents.	A 070		