

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 Initial survey completed on 12/17/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living	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. B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant	A 016		

Division of Health Improvement
LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/25/20

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 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] This REQUIREMENT is not met as evidenced by:	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 7.8.2.16 A (9) B (3, 6-7) 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 employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 3 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 not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 [7.1.12.8 NMAC - N, 01/01/2006] 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: ... D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four (\$74) dollars. Of which, twenty-four (\$24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven (\$7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. E. Fees: The federal bureau of investigation has	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 6 providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview, the facility failed to ensure that the Administrator, Care Director, and all Direct Care Staff (DCs) were in compliance with the following: 1. New Employee Abuse Registry (EAR) inquiries were submitted and clearances received prior to hire by the new facility owners. 2. Submission of the Caregivers Criminal History Screening (CCHSP) applications were submitted within 20 days after hire. This deficient practice could effect the safety and welfare of all residents if the facility staff has a previous history of abuse, neglect, exploitation or a criminal history that would disqualify them from working with residents. The findings are: A. Record review of the Administrator, Care Director, and DCS files revealed that the EAR and CCHSP had not yet been submitted for any of the employees since the change of ownership on 01/01/2019.	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 7 B. On 12/17/19 at 10:00 am, during interview with the Administrator, and Care Director, they confirmed that new EAR's and CCHSP applications were not submitted for clearance since the change of ownership on 01/01/2019.	A 016		
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	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 (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. Conditions or circumstances that usually require continuous nursing care may include but are not	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 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 remain in the facility. Team approval shall be in writing, signed and dated by all team members	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 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 (FSSES); (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		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 11 This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) 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	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCES (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 the resident's estate for moving and 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 4 (R #s 1-4) of 4 (R #s 1-4) residents whose Admission/Discharge Agreements were reviewed for compliance, included the required information in NMAC 7.8.2.20 Regulations for Assisted Living Facilities and Senate Bill (SB) 0335 - 2013. This deficient practice has the potential for residents/resident's estate to be at risk of not receiving monies owed to them and/or being aware of extra charges that could occur for storage of the residents belongings. The finding(s) are: A. Record review of R #s 1-4 Admission/Discharge Agreements revealed that there was no documentation of a refund provision in case of death in compliance with Senate Bill (SB) 0335 - 2013 and NMAC 7.8.2.20. B. On 12/17/19 at 10:00 am, during an interview with the Administrator, and Care Director, they	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 confirmed that there was no documentation in R #s 1-4's Admission/Discharge Agreements of a refund upon death in compliance with Senate Bill (SB) 0335 - 2013 and NMAC 7.8.2.20.	A 020		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 035	Continued From page 14 number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name;	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 035	Continued From page 15 (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 035	Continued From page 16 resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (5) Based on record review and interview the facility failed to ensure for 2 (R #s 1 & 2) of 2 (R #s 1 & 2) whose Medication Administration Records (MARs) were reviewed for compliance included both the brand and generic names for all medications. This deficient practice has the potential to likely result in harm or injury if the	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 035	Continued From page 17 Direct Care Staff (DCS) do not recognize the name of the medication and errors occur. The findings are: Findings related to MAR: A. Record review of R #1's [REDACTED] /19 to [REDACTED] /19 MAR revealed, that it did not include both the brand/generic names for [REDACTED] B. Record review of R #2's [REDACTED] /19 thru [REDACTED] /19 MAR revealed, that it did not include both the brand/generic names for the following medications: [REDACTED] C. On 12/16/19 at 10:00 am, during an interview with the Administrator and Care Director, they confirmed that R #s 1 & 2 12/01/19 thru 12/12/19 MARs were missing either the brand or generic names of the medications listed above.	A 035		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show:	A 065		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(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 065	Continued From page 18 (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 A B (1-5) Based on record review and interview, the facility failed to ensure that a fire drill was conducted and documented monthly on each 8-hour shift (morning, afternoon, graveyard) per quarter. This deficient practice has the potential to effect all 5 (R #s 1-5) residents identified on the census, provided the Care Director on 12/16/19, to be at risk of harm, injury, or death if staff and residents are not aware of how to safely evacuate the building in case of a fire. The findings are: A. Record review of the monthly fire drill records for September, October, and November 2019 revealed all the drills were conducted on the morning (AM) shift and none were conducted on the afternoon or graveyard shifts. B. On 12/17/19 at 10:00 am, during an interview with the Administrator and Care Director, they confirmed that monthly fire drills were not being conducted (each 8-hour shift per quarter) by the facility.	A 065		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/17/2019
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	