STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2109	A. BUILDING: _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLESLEY CARE HOME, LLC	3209 WELLESLEY COURT NE ALBUQUERQUE, NM 87107

(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 000	Initial Comments The following deficiencies were cited during a Full-Onsite survey dated 4/28/17 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint intake NM#30134 was substantiated 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	A 016		

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A 016	Continued From page 1 NMAC. 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		

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A 016	Continued From page 2 This REQUIREMENT is not met as evidenced by: 7.8.2.16 B (3) (6) 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		

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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

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A 016	Continued From page 4 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] 7.1.9.8 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	A 016		

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A 016	Continued From page 5 activity or expense undertaken by the Department. . . . E. Fees: The federal bureau of investigation has 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.	A 016		

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A 016	Continued From page 6 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 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 for 4 (DCS #s 1-4) of 4 (DCS #s 1-4) Direct Care Staff files reviewed for compliance that the: 1. Employee Abuse Registry (EAR) clearances were received prior to hire. 2. The Caregivers Criminal History Screening Program (CCHSP) applications and fingerprints were submitted within twenty (20) days of hire. 3. Documentation/proof of the applications, fingerprints, and clearances were maintained and available for review. This deficient practice has the potential to affect the safety and welfare for all residents if their care and services are being provided by staff with a	A 016		

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A 016	Continued From page 7	A 016		

previous history of abusing, neglecting, or exploiting residents and/or has a felony conviction. The findings are:

A. Record review of the Consolidated Online Registry (COR) report for DCS #1 (hire date 08/09/11) dated 09/09/11, revealed that her EAR clearance was not submitted/received prior to hire.

B. Record review of the COR report for DCS #1 (hire date 08/09/11) dated 09/09/11, revealed that her CCHSP application and fingerprints were not submitted within twenty (20) days after hire.

C. On 04/28/17 at 1:02 pm, during interview with the Administrator, she confirmed that the COR (EAR/CCHSP) dated 09/09/11 for DCS#1 was not completed prior to hire and within twenty (20) days of hire.

D. Record review of DCS #2's Final Registry Report, dated 07/29/16 revealed that her EAR clearance was not received prior to her hire date of 07/11/16.

E. On 04/28/17 at 1:02 pm, during interview with the Administrator, she confirmed that the EAR clearance for DCS #2 was not received prior to her hire date of 07/11/16.

F. Record review of DCS #3's Final Registry Report, dated 04/12/17 revealed that her EAR clearance was not received prior to hire date of 03/27/17.

G. On 04/28/17 at 1:02 pm, during interview with the Administrator, she confirmed that the EAR clearance for DCS #3 was not received prior to her hire date of 03/27/17.

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A 016	Continued From page 8 H. Record review of DC'S #4's (hire date 01/16/17) staff file revealed no documentation of a COR or Final Registry Report to know when/if the EAR was submitted prior to hire and/or the CCHSP application and fingerprints were submitted within 20-days of hire. I. On 04/28/17 at 1:02 pm, during interview with the Administrator, she confirmed that there is not a COR or Final Registry Report for DCS #4 showing dates of when her EAR/CCHSP applications/clearances were submitted and/or received available for review.	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	A 017		

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A 017	Continued From page 9	A 017		

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 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 B, C (1), (2), (8), (10)

Based on record review and interview the facility failed to ensure that 3 (DCS #s 1, 2, and 4) of 4 (DCS #s 1-4) Direct Care Staff whose training files were reviewed for compliance received orientation and annual training in:

1. First Aid
2 Fire Safety and Evacuation
3. Smoking Policy for residents/staff/visitors
4. Emergency Procedures

This deficient practice has the potential for all 16 (R #s 1-16) residents listed on the resident census list provided by the Administrator on 04/26/17, to be at risk of harm if they are being

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A 017	Continued From page 10 provided care by staff who have not received orientation and annual training in: 1. First Aid 2 Fire Safety and Evacuation 3. Smoking Policy for residents/staff/visitors 4. Emergency Procedures The findings are: A. Record review of DCS #1's training file (hire date 08/09/11) revealed no documentation that she received annual training in: 1. Fire Safety and Evacuation 2. Smoking Policy for residents/staff/visitors 3. Emergency Procedures B. Record review of DCS #2's training file (hire date 07/11/16) revealed no documentation that she received orientation training in: 1. First aid 2. Fire safety and Evacuation 3. Smoking policy for residents/staff/visitors C. Record review of DCS #4's training file (hire date 01/16/13) revealed no documentation that she received annual training in: 1. Smoking Policy for residents/staff/visitors 2. Emergency Procedures D. On 04/26/17 at 1:02 pm, during interview with the Administrator, she confirmed that DCS #s 1, 2, and 4 had not completed the 12 hours of orientation or annual training in: 1. First Aid 2. Fire Safety and Evacuation 3. Smoking Policy 4. Emergency Procedures.	A 017		

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A 018	Continued From page 11	A 018		
A 018	7 NMAC 8.2.18 Policies POLICIES: The facility shall have and implement written personnel policies for the following: A. staff, private duty attendant and volunteer qualifications; B. staff, private duty attendant and volunteer conduct; C. staff, private duty attendant and volunteer training policies; D. staff and private duty attendant and volunteer criminal history screening; E. emergency procedures; F. medication administration; G. the retention and maintenance of current and past personnel records; and H. facilities shall maintain records and files that reflect compliance with NM and federal employment rules. [7.8.2.18 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.18 E. Based on record review and interview the facility failed to have and implement a policy that includes emergency procedures for when the Fire Sprinkler System is out for four (4) or more hours. This deficient practice has the potential to negatively affect the safety and welfare of all 16 (R #s 1-16) residents listed on the resident census list provided by the Administrator on 04/26/17. If the facility does not have and implement a policy that includes emergency procedures for when the Fire Sprinkler System is	A 018		

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A 018	Continued From page 12 out for four (4) or more hours then the Direct Care Staff (DCS) may not be able to provide the residents the care and services they need in an emergency situation, putting residents at risk of injury, illness, or death if a fire were to occur while the sprinkler system was not working. The findings are: A. Record review of the facilities Policies and Procedures revealed that there was no policy and procedures for when the Fire Sprinkler System is out for four (4) hours or more. B. On 04/26/17 at 2:17 pm, during interview with the Administrator confirmed that the facility does not have a policy and procedures for when the Fire Sprinkler System is out of service for 4 or more hours.	A 018		
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;	A 020		

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A 020	Continued From page 13 (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 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	A 020		

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	2109	A. BUILDING: _____ B. WING _____	C 04/28/2017

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A 020	Continued From page 14 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; (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.	A 020		

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A 020	Continued From page 15 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) 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	A 020		

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A 020	Continued From page 16 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] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (12) Based on record review and interview the facility failed to ensure that the Admission Agreement stated that it may be terminated "if" an appropriate placement is found for the resident for 7 (R #s 1-7) of 7 (R #s 1-7) residents, whose Admission Agreements were reviewed for compliance. This deficient practice has the potential for residents to be at risk of their Admission Agreement being terminated from the facility without an appropriate place to be discharged to. The findings are: A. Record review of R #1's Admission Agreement dated 07/10/15 revealed, that the Admission Agreement did not include the statement: Admission Agreement may be terminated if an appropriate placement is found for the resident. B. Record review of R #2's Admission Agreement dated 06/29/16 revealed, that the Admission Agreement did not include the statement: Admission Agreement may be terminated if an	A 020		

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A 020	Continued From page 17 appropriate placement is found for the resident. C. Record review of R #3's Admission Agreement dated 03/22/15 revealed, that the Admission Agreement did not include the statement: Admission Agreement may be terminated if an appropriate placement is found for the resident. D. Record review of R #4's Admission Agreement dated 12/18/15 revealed, that the Admission Agreement did not include the statement: Admission Agreement may be terminated if an appropriate placement is found for the resident. E. Record review of R #5's Admission Agreement dated 01/29/17 revealed, that the Admission Agreement did not include the statement: Admission Agreement may be terminated if an appropriate placement is found for the resident. F. Record review of R #6's Admission Agreement dated 07/31/14 revealed, that the Admission Agreement did not include the statement: Admission Agreement may be terminated if an appropriate placement is found for the resident. G. Record review of R #7's Admission Agreement dated 08/29/11 revealed, that the Admission Agreement did not include the statement: Admission Agreement may be terminated if an appropriate placement is found for the resident. H. On 04/26/17 at 11:00 am, during an interview with the Administrator, she confirmed that the Admission Agreements for all seven (7) residents did not include the statement: Admission Agreement may be terminated if an appropriate	A 020		

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A 020	Continued From page 18 placement is found for the resident.	A 020		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status;	A 025		

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A 025	Continued From page 19 (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 B Based on record review and interview the facility failed to ensure that resident Evaluations were reviewed and updated at a minimum of every six (6) months for 1 (R #s 2) of 7 (R #s 1-7) residents whose Evaluations were reviewed for accuracy. These deficient practices have the potential for residents to be at risk of not receiving the appropriate care and assistance needed as changes in their health status occurs. The findings are:	A 025		

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A 025	Continued From page 20 A. Record review of R #2's file revealed, the last Evaluation was completed on 07/07/16, not reviewed or updated at a minimum of every six (6) months. B. On 04/26/17 at 3:00 pm, during an interview with the Administrator, she confirmed that the last Evaluation for R #2 was completed on 07/07/16, and not updated at a minimum of every six (6) months.	A 025		
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	A 026		

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A 026	Continued From page 21 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 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: Refer to 7.8.2.26 A. (3) Based on record review and interview the facility failed to ensure that 1 resident (R #2) of 7 (R #s 1-7) residents whose Individual Service Plans (ISPs) were reviewed for timeliness and accuracy had been reviewed every 6 months. This deficient practice has the potential for the residents to be at risk of not receiving the appropriate care and assistance they need as changes in their health status occurs. The findings are: A. Record review of R #2's file revealed, that the last ISP for R #2 was completed on 07/07/16, and was not reviewed every six (6) months. B. On 04/26/17 at 3:00 pm, during an interview with the Administrator, she confirmed that the last ISP for R #2 was completed on 07/07/16, and	A 026		

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A 026	Continued From page 22 was not reviewed every six (6) months.	A 026		
A 030	7 NMAC 8.2.30 Handling of Resident Funds HANDLING OF RESIDENT FUNDS: A. Each resident has the right to manage their personal funds in accordance with state or federal laws. B. If the facility agrees, the resident may entrust his or her personal funds to the facility for safekeeping and management. In such cases, the facility shall: (1) have written authorization from the resident or his or her surrogate decision maker; (2) maintain a written record of all financial transactions and arrangements involving the resident's funds and make this written record available upon request, to the resident, his or her surrogate decision maker and the licensing authority; (3) safeguard any and all funds received from the resident in an account separate from all other funds of, or held by, the facility; (4) upon written or verbal request by the resident or his or her surrogate decision maker, return to the resident all or any part of the resident's funds given to the facility for safekeeping and management, including all accrued interest if applicable; and (5) upon the resident's death, will transfer all personal funds held by the facility to the resident ' s estate in accordance with Section 45-3-709 NMSA 1978. C. The facility shall not commingle the resident ' s funds, valuables or property with that of the licensee. Resident ' s funds, valuables or property shall be maintained separate, intact and free from any liability of the licensee, staff and management.	A 030		

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A 030	Continued From page 23 [7.8.2.30 NMAC - Rp, 7.8.2.31 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.30 B (1) (2) Based on record review and interview the facility failed to ensure they obtain written consent to handle residents' personal funds and to maintain an accurate accounting of resident funds for 1 (R #9) of 1 (R #9) resident identified by the Administrator as having funds maintained by the facility. If the facility does not obtain consent to manage the resident's funds and does not keep an accurate accounting of their monies, then residents could have their monies mismanaged and/or be exploited. The findings are: A. Record review of R #9's resident file revealed there is not a written signed consent form giving the facility permission to handling resident's funds. B. Record request for R #9's record of handling resident's funds transactions revealed, that the facility does not have a record of transactions for R #9's funds. C. On 04/28/17 at 11:49 am, during an interview with the Administrator, she confirmed that there is not a written signed consent form for R #9 stating that the facility is handling the resident's funds. She stated that she is managing R #9's funds and does not keep a record of transactions and since [resident's name] credit/debit card was stolen, I began to take care of resident's funds by keeping their funds in an envelope locked in a drawer in the office."	A 030		

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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 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. B	A 032		

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A 032	Continued From page 25 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W, 8 B (2), 10 C 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. C. All licensed health care facilities shall conduct a complete investigation and report the actions taken and conclusions reached by the facility	A 032		

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A 032	Continued From page 26 within five (5) days of discovery of the incident. Based on record review and interview the facility failed to ensure for one (1) self reported incident of exploitation of a resident by a Direct Care Staff (DCS), that they submitted documentation of the internal investigation within 5 business days after the incident occurred to the Licensing Authority. If the facility does not submit a five (5) day follow-up investigation report to the Licensing Authority then all 16 (R #s 1-16) residents listed on the resident census list, provided by the Administrator on 04/26/17, may be at risk of being exploited if there is no oversite by the Licensing Authority to ensure that a thorough investigation has been completed and what precautions/interventions have been implemented to prevent future occurrences. The findings are: A. Record request of the facility's follow-up investigation report submitted to the Licensing Authority within five (5) business days following the incident of exploitation of a Resident (R #1) by Direct Care Staff (DCS) #2, revealed no documentation of an internal investigation being conducted or a follow-up investigation report being submitted to the Licensing Authority. B. On 04/28/17 at 2:56 pm, during an interview with the Administrator, she confirmed that the facility did not submit a follow-up investigation report within five (5) business days after the incident occurred to the Licensing Authority. She stated "I just fired her."	A 032		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all	A 033		

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	2109	A. BUILDING: _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLESLEY CARE HOME, LLC	3209 WELLESLEY COURT NE ALBUQUERQUE, NM 87107

(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 033	Continued From page 27 residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment;	A 033		

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A 033	Continued From page 28 (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any	A 033		

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A 033	Continued From page 29 state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.1.13.11 CONSEQUENCES OF LICENSED HEALTH CARE FACILITY NONCOMPLIANCE: A. The department or other governmental agency	A 033		

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A 033	Continued From page 30 having regulatory enforcement authority over a licensed health care facility may sanction a licensed health care facility or in accordance with applicable law if the licensed health care facility fails to report incidents of abuse, neglect or exploitation or fails to provide or fails to maintain evidence of an existing incident management system and employee training documentation as set forth by this rule, fails to take reasonable measures to protect consumers from abuse, neglect or exploitation, or any other violation of this rule. B. Such sanctions may include revocation or suspension of license, directed plan of correction, intermediate sanctions or civil monetary penalty up to five thousand dollars ($5,000) per instance. C. All confirmed incident investigations conducted by the department hold the licensed health care facility responsible for the actions of the employee in their employment with the following exception: any employee found to have caused the abuse, neglect or exploitation shall be held accountable independent of the licensed health care facility when the facility has complied with all requirements of this rule and the employee acts outside of the provider's system. The employee shall be subject to the Employee Abuse Registry Act, or referred to the appropriate certification or licensing authority and reported to law enforcement agencies when appropriate. [7.1.13.11 NMAC - Rp, 7.1.13.12 NMAC, 7/1/14] 7.8.2.33 D (11) (a) Based on record review and interview the facility failed to ensure that 1 (R #1) of 1 (R #1) resident was free from financial exploitation and theft by Direct Care Staff (DCS). This deficient practice has the potential for all residents to be at risk of	A 033		

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A 033	Continued From page 31	A 033		

being financially abused and/or exploited by DCS staff, putting the residents financial well being in jeopardy. The findings are:

Findings related to late Employee Abuse Registry (EAR), Criminal Caregivers History Screening (CCHSP) clearances and Abuse/Neglect/Exploitation training.

A. Record review of the Consolidated Online Registry (COR) report for DCS #1 (hire date 08/09/11) dated 09/09/11, revealed that her EAR clearance was not submitted/received prior to hire.

B. Record review of the COR report for DCS #1 (hire date 08/09/11) dated 09/09/11, revealed that her CCHSP application and fingerprints were not submitted within twenty (20) days after hire.

C. On 04/28/17 at 1:02 pm, during interview with the Administrator, she confirmed that the COR (EAR/CCHSP) dated 09/09/11 for DCS #1 was not completed prior to hire and within twenty (20) days of hire.

D. Record review of DCS #2's Final Registry Report, dated 07/29/16 revealed that her EAR clearance was not received prior to her hire date of 07/11/16.

E. On 04/28/17 at 1:02 pm, during interview with the Administrator, she confirmed that the EAR clearance for DCS #2 was not received prior to her hire date of 07/11/16.

F. Record review of DC'S #3's Final Registry Report, dated 04/12/17 revealed that her EAR clearance was not received prior to hire date of 03/27/17.

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A 033	Continued From page 32 G. On 04/28/17 at 1:02 pm, during interview with the Administrator, she confirmed that the EAR clearance for DCS #3 was not received prior to her hire date of 03/27/17. H. Record review of DCS #4's (hire date 01/16/17) resident file revealed no documentation of a COR or Final Registry Report to know when/if the EAR was submitted prior to hire and/or the CCHSP application and fingerprints were submitted within 20-days of hire. I. On 04/28/17 at 1:02 pm, during interview with the Administrator, she confirmed that there is not a COR or Final Registry Report showing dates of when the EAR/CCHSP applications/clearances were submitted and/or received available for review for DCS #4. Finding related to DCS #2's Abuse/Neglect/Exploitation (ANE) training: J. Record review of DCS #2's training form revealed that she had received training in Abuse/Neglect/Exploitation on 07/11/16. K. Record review of the facility's policy on ANE defines exploitation as: "The deliberate misplacement of a resident's property, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. L. On 04/26/17 at 1:02 pm, during interview with the Administrator, she confirmed that DCS #2 had received training in Abuse/Neglect/Exploitation on 07/11/16.	A 033		

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Findings related to R #1 exploitation:

M. Record review of the facility's incident report to the Licensing Authority, dated 09/14/16 revealed that the facility was notified by R #1's daughter that someone (possibly a DCS) had stolen and used her mother's credit card at a number of local businesses spending over $1,000.

N. Record review of R #1's bank print out dated 06/21/16 to 09/12/16 revealed that there were forty-three (43) unauthorized listed transactions totally $1,149.92 made by DCS #2 using R #1's credit card from 07/28/17 to 09/12/17.

O. Record review of the police report dated 09/12/16 revealed that the officer was able to obtain a security camera photograph of the person using R #1's credit card at a local business, who was identified by the facility as DCS #2.

P. On 04/26/17 at 1:19 pm, during interview with R #1, she stated that she had her purse at the facility including her bank card. She does not remember exactly where her purse was in her room, only that her bank card was stolen. R #1 reported that the police were able to get a picture of DCS #2 using her credit card at a local business. The amount stolen was around $1,000.00 dollars, but she (R #1) does not know the exact amount. R #1 says the facility Administrator worked to help resolve the issue and the lady (DCS #2) was fired right away.

Q. On 04/26/17 at 1:35 pm, during interview with the Administrator, she stated that DCS #2 used R #1's credit card at a number of local fast food, grocery stores, and other local businesses. The

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A 033	Continued From page 34 Administrator says that the Police Department was notified of the stolen bank card. The officer did show her a picture of the person using the credit card from a local business and she identified the person as DCS #2. She said that DCS #2 had already gone home for the day when she identified her as the person in the picture, so she called DCS #2 and told her that she knew DCS #2 stole R #1's credit card and used it. The Administrator informed DCS #2 at that time that she was terminated. The Administrator stated that she is not sure of the exact amount (approximately $1000,00) that DCS #2 stole from R #1 using her bank card, but R #1's daughter would know. R. Record review of DCS #2's timecard for the week of 07/25/16 thru 08/04/16 revealed that she worked from 2:31 pm to 7:55 pm, on 07/28/17, the day the unusual charges began on R #1's bank records. S. Record review of a written statement dated 04/27/17 by R#1's daughter indicated that on 09/12/16 she received an email from her mother's bank informing her that her mother's [R #1] "debit card" had been canceled due to unusual charges. She then went to the bank to get a record of the charges, called her mother and told her the card had been used. R #1 checked her purse and the card was gone. T. On 04/28/17 at 10:30 am, during interview with the Supervisor regarding the incident of exploitation of R #1, she stated that she had received a call from the Administrator on 09/13/17 (her day off) to inform her that R #1's daughter called to report that her mother's bank card had been used by someone other than R #1. The Supervisor then called R #1's daughter and went	A 033		

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A 033	Continued From page 35 to the daughter's home to find out more information about the specific transactions. Once she received the information the Supervisor then went home and began calling the businesses where the card had been used. When she called one local business, she was informed that they had a security camera photograph of the person using R #1's bank card, and she identified the person as DCS #2. U. Record review of DCS #2's Final Registry Report, dated 07/29/16 revealed that her EAR clearance was not until one (1) day after the unauthorized charges began appearing on R #1's bank card. 07/11/16. V. On 04/28/17 at 1:02 pm, during interview with the Administrator, she confirmed that the EAR clearance for DCS #2 was not received until 07/29/16, (which was one (1) day after the unauthorized charges began appearing on R #1's bank card). 7.8.2.33 D (11) (q) Based on record review and interview the facility failed to ensure for all 7 (R #s 1-7) of 7 (R #'s 1-7) residents that the admissions agreement states a reason for the thirty day termination. This deficient practice has the potential for residents to be at risk of emotional distress if terminated from unjustified discharges. The findings are: Findings for Unjustified Discharges: A. Record review of R #1's Admission Agreement	A 033		

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A 033	Continued From page 36 dated 07/10/15 revealed, that the Admission Agreement's statement: "thirty day notice at any time for termination" does not include that a reason for termination will be given by the facility. B. Record review of R #2's Admission Agreement dated 06/29/16 revealed, that the Admission Agreement's statement: "thirty day notice at any time for termination" does not include that a reason for termination will be given by the facility. C. Record review of R #3's Admission Agreement dated 03/22/15 revealed, that the Admission Agreement's statement: "thirty day notice at any time for termination" does not include that a reason for termination will be given by the facility. D. Record review of R #4's Admission Agreement dated 12/18/15 revealed, that the Admission Agreement's statement: "thirty day notice at any time for termination" does not include that a reason for termination will be given by the facility. E. Record review of R #5's Admission Agreement dated 01/29/17 revealed, that the Admission Agreement's statement: "thirty day notice at any time for termination" does not include that a reason for termination will be given by the facility. F. Record review of R #6's Admission Agreement dated 07/31/14 revealed, that the Admission Agreement's statement: "thirty day notice at any time for termination" does not include that a reason for termination will be given by the facility. G. Record review of R #7's Admission Agreement dated 08/29/11 revealed, that the Admission Agreement's statement: "thirty day notice at any time for termination" does not include that a	A 033		

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A 033	Continued From page 37 reason for termination will be given by the facility. H. On 04/26/17 at 11:00 am, during an interview with the Administrator, she confirmed that for all seven residents that Admission Agreement's statement: "thirty day notice at any time for termination" does not include that a reason for termination will be given by the facility.	A 033		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications.	A 034		

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A 034	Continued From page 38 (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall	A 034		

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A 034	Continued From page 39 be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (3) (4) (7) Reference NFPA 99 (Healthcare Facilities Code) 2012 Edition NFPA 99. 11.3 Cylinder and Container Storage	A 034		

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A 034	Continued From page 40 Requirements. 11.3.1* Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. 11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. 11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour 11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations. 11.3.2.8 Cylinder valve protection caps shall	A 034		

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A 034	Continued From page 41 comply with 11.6.2.3. 11.3.2.9 Gas cylinder and liquefied gas container storage shall comply with 5.1.3.5.12. 11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 11.3.3.1 and 11.3.3.2. 11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not be required to be stored in enclosures. 11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. 11.3.3.3 When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders. 11.3.3.4 Individual small-size (A, B, D, or E) cylinders available for immediate use in patient care areas shall not be considered to be in storage. 11.3.3.5 Cylinders shall not be chained to portable or movable apparatus such as beds and oxygen tents. 11.3.4 Signs. 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following wording as a minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING 2012 Edition Based on observation and interview, the facility failed to ensure that:	A 034		

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A 034	Continued From page 42 1. Oxygen cylinder tanks were secured and stored correctly. 2. "Oxygen in Use" signs were posted outside the rooms were oxygen is being used. 3. Oxygen cylinder tank storage area has a flow of air and free from combustibles. 4. Medication refrigerator was secured. 5. Medications were labeled with resident's information. These deficient practices has the potential for all 16 (R #s 1-16) residents identified on the resident census list provided by the Administrator on 04/26/17, to be at risk of illness, harm or death if: 1. Oxygen cylinder tanks were to be knocked over and may act like a missile. 2. In the event of a fire: a. Combustibles stored with oxygen cylinder tanks accelerates the fire. b. If "oxygen in use" signs are not posted; residents, staff and visitors are unaware of hazardous areas to avoid. 3. Residents are able to open medication refrigerator and take any or all medications. 4. Residents are being assisted with wrong medications. The findings are: Findings for Oxygen Cylinder Tanks: A. On 04/25/17 at 11:30 am, during observation of R #10's room revealed: 1. Two unsecured oxygen cylinder tanks laying down in a laundry basket, at the bottom of the resident's closet, stored with clothes, shoes, and blankets. 2. No "oxygen in use" sign posted on the door. B. On 04/25/17 at 11:35 am, during observation	A 034		

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A 034	Continued From page 43 of room shared by R #2 and R #11 revealed, no "oxygen in use" sign posted on the door. C. On 04/25/17 at 11:40 am, during observation of room shared by R #4 and R #8 revealed, no "oxygen in use" sign on the door. D. On 04/25/17 at 11:45 am, during observation of shared room R #7 and R #12 revealed, no "oxygen in use" sign on the door. E. On 04/25/17 at 1:15 pm, during an interview with DCS #1, she confirmed that R #10 has two oxygen cylinder tanks unsecured laying down in a laundry basket in the resident's closet with clothes, shoes and blankets. R # 2, 4, 7, 8, 11, and 12's rooms have no oxygen in use signs posted on the doors. Findings for Medication Refrigerator: F. On 04/25/17 at 1:25 pm, during an observation of the medication refrigerator it was observed to be unlocked. G. On 04/25/17 at 2:15 pm during an interview with DCS #1, she confirmed that the medication refrigerator was unlocked. Findings for Oxygen Cylinder Tank Storage Area: H. On 04/26/17 at 9:25 am, during observation twenty-six (26) tall oxygen cylinder tanks were observed being stored in an unventilated shed with combustibles (boxes, supplies on plastic shelving, carpet squares, furniture, DME (durable medical equipment) and cleaning supplies). I. On 04/26/17 at 9:41 am, during interview with	A 034		

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A 034	Continued From page 44 the Administrator, she confirmed the observation of the twenty-six (26) tall oxygen cylinder tanks being stored in an unventilated shed with combustibles (boxes, supplies on plastic shelving, carpet squares, furniture, DME (durable medical equipment) and cleaning supplies). J. On 04/26/17 at 12:38 pm, during observation and interview with DCS #3 about the shed containing the twenty-six (26) oxygen cylinder tanks the floors were observed to be made of wood. DCS #3 confirmed that the shed floors were made of wood. Findings related to medication storage: K. On 04/28/17 at 1:50 pm, during observation of the medication cart the following was observed: 1. R #2's over the counter (otc) Cranberry 25, 2000 mg (milligrams) with Vitamin C (urinary health) medication was not labeled with his name or physician's order. 2. R #3's (otc) probiotic (digestion) medication was not labeled with her name or physician's order. 3. R #4's medication revealed the following issues: a. Loratadine (otc allergy reliever) 10 mg had no physician's orders listed on the medication container. b. MAPAP (Tylenol) 325 mg (pain) did not have both the brand/generic name on the medication container. c. Depacote (seizures); the physician's PRN (as needed) orders were not documented on the medication container. d. Sodium Chloride, USP (United States Pharmacopeia) 0.9% (saline for nebulizer) was not labeled with her name or the physician's orders.	A 034		

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A 034	Continued From page 45 4. R #7's MAPAP (Tylenol) 500 mg (pain) did not have both the brand/generic name of the medication container. L. On 04/28/17 at 2:33 pm, during interview with the Administrator, she confirmed the medication findings listed above for R #s 2, 3, 4 and 7.	A 034		
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.	A 035		

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A 035	Continued From page 46 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 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	A 035		

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A 035	Continued From page 47 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; (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	A 035		

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A 035	Continued From page 48 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 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 (3) (16) Based on observation, record review and interview the facility failed to ensure that: 1. Physician orders were in place for crushed	A 035		

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medications.
2. The Medication Administration Records (MAR) were accurate and contained documentation of all required information.
3. Prescribed medications for PRN (as needed) are available.

These deficient practices have the potential to negatively affect the health, safety, and welfare of residents if:
1. There are no Physician orders for crushed medications to be mixed with food.
2. The information on the MARs is not accurate and complete.
3. The facility does not have the prescribed medications for PRN.

The findings for Medications

A. On 04/28/17 at 7:00 am, during observation Direct Care Staff (DCS) #5 was observed to crush medication for R #8 and mixed crushed medication with yogurt and handed the spoon with the medication and yogurt to R #8.

B. Record review of R #8's resident file revealed, no physician's order for medications to be crushed and/or added to food.

C. On 04/28/17 at 9:10 am, during an interview with DCS #5, she confirmed that there are no Physicians orders for R #8 to have any of her medications crushed and added to food.

Findings for MAR

D. Record review of R #1's MAR dated 04/01/17 to 04/28/17 revealed:
1. There are five (5) sets of initials of medication technicians who are assisting with

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medications and only one (1) medication technician's initials and signature are listed on the MAR for reference to who is assisting with medications;
2. The resident's physician is not listed on the MAR.

E. Record review of R #2's MAR dated 04/01/17 to 04/28/17 revealed:
1. There are five (5) sets of initials of medication technicians who are assisting with medications and only one (1) medication technician's initials and signature are listed on the MAR for reference to who is assisting with medications;
2. The resident's physician is not listed on the MAR.

F. Record review of R #3's MAR dated 04/01/17 to 04/28/17 revealed:
1. There are five (5) sets of initials of medication technicians who are assisting with medications and only one (1) medication technician's initials and signature are listed on the MAR for reference to who is assisting with medications;
2. The resident's physician is not listed on the MAR.

G. Record review of R #4's MAR dated 04/01/17 to 04/28/17 revealed:
1. There are five (5) sets of initials of medication technicians who are assisting with medications and only one (1) medication technician's initials and signature are listed on the MAR for reference to who is assisting with medications;
2. The resident's physician is not listed on the MAR.

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A 035	Continued From page 51 H. Record review of R #5's MAR dated 04/01/17 to 04/28/17 revealed: 1. There are four (4) sets of initials of medication technicians who are assisting with medications and only one (1) medication technician's initials and signature are listed on the MAR for reference to who is assisting with medications; 2. The resident's physician is not listed on the MAR. I. Record review of R #6's MAR dated 04/01/17 to 04/28/17 revealed: 1. There are five (5) sets of initials of medication technicians who are assisting with medications and only one (1) medication technician's initials and signature are listed on the MAR for reference to who is assisting with medications; 2. The resident's physician is not listed on the MAR. J. Record review of R #7's MAR dated 04/01/17 to 04/28/17 revealed: 1. There are five (5) sets of initials of medication technicians who are assisting with medications and only one (1) medication technician's initials and signature are listed on the MAR for reference to who is assisting with medications; 2. The resident's physician is not listed on the MAR. K. On 04/28/17 at 1:00 pm, during an interview with the Administrator, she confirmed that the 04/01/17 to 04/28/17 MARs for R #s 1-7, are missing initials and signatures of medication technicians for reference to who is assisting with medications and the resident's physicians are not listed.	A 035		

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A 035	Continued From page 52 L. On 04/28/17 at 1:50 pm, observation of the medication cart revealed the following: 1. Zofran/Ondasteron (nausea/vomiting) 4 milligrams (mg), was still listed on the 04/01/17 to 04/28/17 MAR for R #4, there was no physician's order for the medication to be discontinued (DC), and there was no medication. 2. Hycotuss (cough syrup), no longer taking (per Administrator), was still listed on the 04/01/17- 4/28/17 MAR, for R #4 and there was no physician's order for the medication to be discontinued (DC), and there was no medication. M. On 04/28/17 at 2:33 pm, during an interview with the Administrator, she confirmed that the Zofran/Ondasteron (nausea/vomiting) 4mg, and Hycotuss (cough syrup), for R #4 are listed on the 04/01/17 to 04/28/17 MAR; are not on the medication cart. She stated: "The residents do not take that particular medications often. I order these medications when they need them."	A 035		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the	A 036		

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A 036	Continued From page 53 premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage;	A 036		

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A 036	Continued From page 54 (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall	A 036		

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A 036	Continued From page 55 be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and	A 036		

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A 036	Continued From page 56 a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water	A 036		

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A 036	Continued From page 57 back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.36 A (d) C (5) D (3) Based on observation and interview the facility	A 036		

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A 036	Continued From page 58 failed to ensure that: 1. Food stored in the refrigerator is labeled and dated. 2. Staff is wearing hair nets or caps when handling food. 3. A weekly menu is posted where residents and families are able to view it. This deficient practice has the potential for all 16 (R#s 1-16) identified on the resident census list provided by the Administrator on 04/26/17, to be at risk of eating contaminated and spoiled food, and unable to make meal choices in advance. The findings are: A. On 04/25/17 at 1:15 pm, during observation Direct Care Staff (DCS) #1 was observed not wearing a hair net or cap while preparing and cooking food. During an interview with DCS #1, she confirmed that she was not wearing a hair net or cap while preparing and cooking food. B. On 04/25/17 at 1:25 pm, during observation of the kitchen, the weekly menu was observed to be posted on the refrigerator in the kitchen where residents/families/visitors were unable to view it. During an interview with DCS #1, she confirmed that they post the menu on the refrigerator and stated that residents usually ask what is the meal for today. C. On 04/25/17 at 1:42 pm, during observation of the kitchen, the refrigerator revealed the following: 1. 1-5 lb (pound) bag of cheese, used, not dated when opened. 2. 1-Large bag of sliced cheese, used, not dated when opened. 3. 1-5 lb tub of butter spread, used, not dated when opened.	A 036		

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A 036	Continued From page 59 4. 1-64 fluid ounce bottle of grape juice, used, opened not dated. D. On 04/25/17 at 2:10 pm, during an interview with DCS #1, she confirmed that the food listed above was not dated when opened.	A 036		
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread	A 037		

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A 037	Continued From page 60 shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet. B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (9) (10) Based on observation and interview the facility failed to ensure that the: 1. Cleaning supplies were kept in a secure room or cabinet and not accessible to residents. 2. The clean linen closet was well ventilated. This deficient practice has the potential for all 16 (R #s 1-16) residents listed on the resident census list, provided by the Administrator to be a risk of illness, harm, or injury if the: 1. Cleaning supplies are accidentally spilled on the floor causing residents to fall, consumed by residents, and the mop/mop bucket are contaminated by germs and/or bacteria. 2. Clean linens become contaminated with bacteria. The findings are:	A 037		

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A 037	Continued From page 61 A. On 04/25/17 at 2:33 pm, during observation of bathroom #3 the following was observed: 1. 1-100 oz (ounce) bottle of pine cleaner sitting on the bathtub and accessible to residents. 2. The mop and mop bucket were being stored in the residents' bathtub. B. On 04/25/17 at 2:45 pm, during observation of the linen closet in the dining room it was observed to not be ventilated, linens were stored in the same closet as the cleaning supplies, and the lock on the door did not always work. C. On 04/25/17 at 2:57 pm, during observation and interview with (DCS #1), she confirmed that: 1. The bottle of pine cleaner and the mop/mop bucket were being stored in the bathtub of bathroom #3 and accessible to residents. 2. The clean linen closet was not ventilated, had clean linens stored in the same closet as the cleaning supplies, and had a door with a lock that did not always work.	A 037		
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be	A 038		

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A 038	Continued From page 62 stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.38 A, B Based on observation and interview the facility failed to ensure that the: 1. Interior and exterior of the facility is free of odors, safety hazards, insects, and accumulations of dirt and dust. 2. Common living areas and bathrooms are cleaned as necessary to maintain a clean and sanitary environment. 3. Storage areas are kept clean, organized, and combustibles (cleaning supplies/rags/paint) are stored in metal containers in an approved storage area that is well ventilated. 4. Fire prevention sprinkler heads/emergency lighting were kept clean and dust/dirt free to ensure they work correctly. These deficient practices have the potential for of all 16 (R #s 1-16) residents, listed on the resident census list, provided by the Administrator on 04/26/17, to be at an increased risk of illness, injury, or death if the facility and storage areas are not maintained in a:	A 038		

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A 038	Continued From page 63 1. Clean, organized, safe and sanitary condition and combustibles are stored only in metal containers in an approved area. 2. Free of insects, odors and tripping hazards. 3. Free from accumulation of dust and dirt and the fire prevention sprinkler heads/emergency lighting are kept clean and dust/dirt free to ensure they work correctly. The findings are: Findings related to interior of the facility. A. On 04/25/17 at 10:53 am thru 11:57 am, during tour of the facility the following was observed. 1. 6 of 6 emergency light fixtures were dirty. 2. 6 of 9 window blinds were dirty and 2 were broken. 3. 5 of 9 windows were dirty. 4. 7 of 9 window sills were dirty and 1 had dirt build up in the window slide area. 5. 2 of 9 window screens were dirty. 6. 4 of 9 resident rooms had floor tiles that were broken, chipped, and missing pieces, creating a possible tripping hazard. 7. 11 of 16 air vents were dirty and dusty. 8. 8 of 13 sprinkler heads were dirty and dusty. 9. 3 of 9 resident rooms had urine odors. B. On 04/25/17 at 1:37 pm, during observation and interview with DCS #1, she confirmed all of the findings listed above for resident rooms, hallway and living room. C. On 04/25/17 from 2:25 pm to 2:33 pm, during observation of bathroom (BR) #s 1 & 3, the following was observed: 1. BR #1's shower had rust in the shower	A 038		

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A 038	Continued From page 64 stall. 2. BR #3's used by residents and the only available bathtub had: a. The mop and mop bucket being stored in the bathtub b. The window was very dirty. c. There were spider webs on the walls in the corner of the shower stall d. The AC vents and sprinkler heads were dirty and dusty. e. There were multiple drywall penetrations and missing tiles in the shower. D. On 04/25/17 at 2:45 pm, during observation and interview with DCS #1, she confirmed the findings listed above in BR #s 1 and 3. Findings related to the storage closet. E. On 04/28/17 at 3:05 pm, during observation with the Administrator, of the rubber storage closet next to the back wall of the facility, revealed that the storage closet: 1. Was made of rubber (combustible), unventilated, and not a safe storage area for combustible items. 2. Was not maintained in a safe, sanitary, and presentable condition. 3. Contained tools, cans of paint, cleaning supplies, floor tiles, dirt on the shelves and floor (thrown about) and other combustible items creating a fire hazard. 4. Door was broken, preventing it from being secured, and making it accessible to residents and others. F. On 04/28/17 at 3:10 pm, during interview with Administrator, she confirmed the storage closet was not maintained in a organized, clean and sanitary condition, and contained combustibles	A 038		

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A 038	Continued From page 65 (paint, cleaning supplies, rags) creating a potential fire hazard and that need to be stored in an approved area that is well ventilated.	A 038		
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.42 (A) (B) Based on record review, observation, and interview the facility failed to ensure that the: 1. Floors are in good condition 2. Hot water heaters have been inspected annually, are in good condition, free of corrosion, and the room door is in good repair. 3. The storage closet was appropriate for storing combustibles, safe, presentable, organized, free from accumulation of refuse or other items that would create a fire hazard. 4. And sinks drain correctly and do not get	A 042		

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A 042	Continued From page 66 blocked/backed up. This deficient practice has the potential for all 16 (R #s 1-16) residents listed on the resident census list, provided by the Administrator on 04/26/17 to be at risk of harm, illness, injury, or death if: 1. Residents trip/fall due to broken floor tiles. 2. Residents are harmed or injured if the hot water heater brakes and releases scalding hot water into resident rooms and common area and/or the door cannot be shut securely to prevent resident access to the hot water heater. 3. Residents are harmed, injured, or killed if a fire or explosion were to occur. 4. Residents become ill from bacteria/germs if they are not able to use the sink to wash themselves and/or from stagnate water build-up in the sinks. The findings are: A. On 04/25/17 at 10:53 am thru 11:57 am, during tour of the facility resident rooms (RR #s 1,2, 6, 7) had floor tiles that were broken and chipped, missing pieces, creating a possible tripping hazard. B. On 04/25/17 at 1:37 pm, during observation and interview with Direct Care Staff (DCS), she confirmed that #1, 4 resident (RR #s 1,2, 6, 7) had floor tiles that were broken and chipped, missing pieces, creating a possible tripping hazard. Findings related to hot water heater C. On 04/25/17 at 1:39 pm, during observation of the hot water heater next to bathroom (BR #3) a pipe to water heater was observed to have a heavy build up of corrosion on it and the bottom hinge to the closet door was observed to be broken, making opening and shutting the door	A 042		

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	2109	A. BUILDING: _____ B. WING _____	C 04/28/2017

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A 042	Continued From page 67 difficult. D. On 04/25/17 at 1:41 pm, during interview with DCS #1, she confirmed that the pipe to the hot water heater next to BR #3 had a heavy build up of corrosion on it and that the bottom hinge was broken on the closet door and it does not open/close easily. E. On 04/26/17 at 3:01 pm, during interview with the Administrator, she confirmed that the hot water heater next to BR #3 had corrosion on the pipe and that the bottom hinge on the closet door was broken and prevents it from opening/closing easily. F. Record request for the annual inspection report for the two (2) facility hot water heaters revealed that the water heaters had not been inspected annually. G. On 04/26/17 at 3:01 pm, during interview with the Administrator, she confirmed that hot water heaters had not been inspected annually and does not know when they were last inspected.. Finding related to the storage shed H. On 04/28/17 at 3:05 pm, during observation of the rubber storage closet next to back wall of the facility, revealed that the storage closet: 1. Was made of rubber (combustible), unventilated, and not a safe storage area for combustibles. 2. Was not maintained in a safe, sanitary, and presentable condition. 3. Contained tools, cans of paint, cleaning supplies, floor tiles, dirt, on the shelves and floor (thrown about) and other combustible items creating a potential fire hazard.	A 042		

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A 042	Continued From page 68 4. Door was broken and preventing it from being secured and making it accessible to residents and others. I. On 04/28/17 at 3:10 pm, during interview with Administrator, she confirmed the findings listed above for the rubber storage closet, that it is accessible to residents, and is a fire hazard. Findings related to drywall penetrations J. On 04/25/17 at 2:33 pm, during observation of BR #3, three penetrations (holes) in the drywall were observed in in the walls, shower, and under the sink. K. On 04/25/17 at 2:57 pm, during observation and interview with DCS #1, she confirmed the penetrations in the drywall in BR #3. L. On 04/26/17 at 3:20 pm, during observation the furnace (electric) closet revealed, there was a large penetration in the drywall on the ceiling. Pieces of the drywall were also observed hanging down into the furnace closet. M. On 04/26/17 at 3:25 pm, during interview with the Administrator, she confirmed the drywall penetrations in the BR #3 and the furnace closet with the pieces of drywall hanging down from ceiling. Findings for Bathroom Sink N. On 04/25/17 at 2:15 pm, during an observation of BR #1, the water in the sink was observed to not be draining. O. On 04/25/17 at 2:50 pm, during an interview with DCS #1, she confirmed that the sink in BR	A 042		

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A 042	Continued From page 69 #1 was not draining, and stated it often gets blocked.	A 042		
A 045	7 NMAC 8.2.45 Water WATER: Pursuant to the current New Mexico drinking water requirements, 7.6.2.9 NMAC. A. The water supply system shall be constructed, protected, operated and maintained in conformance with applicable local, state and federal laws, ordinances and regulations. B. Where a facility is supplied by its own water system, the system shall meet the sampling and construction requirement of a non-community water system as defined by the current New Mexico drinking water requirements. C. All water that is not piped into the facility directly from a public water supply system shall be from an approved source, disinfected, transported, handled, stored and dispensed in a sanitary manner. Such water shall be prevented from entering potable water systems by appropriate cross connection and backflow prevention devices. D. Hot and cold running water, under pressure shall be provided in all areas where food is prepared and where equipment and utensils are washed, sinks, lavatories, washrooms and laundries. E. The hot water temperature that is accessible to residents shall be maintained at a minimum of ninety-five (95) degrees fahrenheit and a maximum of one hundred ten (110) degrees fahrenheit. Hot water in excess of one hundred ten (110) degrees fahrenheit is permitted in kitchen and laundry areas, provided that residents are supervised in order to prevent injury. [7.8.2.45 NMAC - Rp, 7.8.2.46 NMAC,	A 045		

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A 045	Continued From page 70 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.45 E Based on observation and interview, the facility failed to ensure that the hot water temperatures were maintained within the safe range of 95 degrees Fahrenheit (F) and 110 degrees F. This deficient practice has the potential for all 16 (R #'s 1-16) residents identified on the resident census list provided by the Administrator on 04/26/17, to be at risk of injury from scalding hot water. The findings are: A. On 02/25/17 at 2:15 pm, during observation of restroom #1, the hot water temperature from the sink faucet was at 118 degrees F. B. On 02/25/17 at 2:20 pm, during observation of restroom #2, the hot water temperature from the sink faucet was at 118 degrees F. C. On 02/25/17 at 2:50 pm, during an interview with the Direct Care Staff (DCS #1) confirmed that the water temperatures from Bathroom #1 and #2 sink faucets are at 118 degrees F.	A 045		
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	A 047		

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A 047	Continued From page 71 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 A, D, E Based on observation and interview the facility failed to ensure that the: 1. Emergency light fixtures were in working order. 2. Lighting fixtures have covers to prevent glare to residents/staff. This deficient practice has the potential for all 16 (R #s 1-16) residents listed on the resident census list, provided by the Administrator on 04/26/17, to be at risk of injury or death in the event of a power failure if the emergency lighting system has not been maintained and does not illuminate a clear path to the nearest exit for	A 047		

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A 047	Continued From page 72 residents/staff to safely evacuate the facility if a fire occurs. The findings are: A. On 04/25/17 at 10:53 am, during observation of the emergency light fixtures 3 of 6 had lights fixtures in the hallway that were observed to not be working and that 1 of the lights on the emergency light fixture over the dining room exit door was missing a cover. B. 04/25/17 at 11:08 am, during interview with DCS #1, she confirmed that 3 of 6 emergency light fixtures in the hallway were not working and that 1 of the lights on the emergency light fixture over the dining room exit door was missing a cover.	A 047		
A 048	7 NMAC 8.2.48 Electrical System ELECTRICAL SYSTEM: A. All fuse and breaker boxes shall be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility shall know the location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances shall be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear. (2) Extension cords shall not be used. The use of a multi-socket united laboratories approved (U/L APPROVED) surge protector with integrated circuit breaker no greater than six (6) feet in length is permitted for the intended purpose and not as an extension cord. [7.8.2.48 NMAC - Rp, 7.8.2.49 NMAC, 01/15/2010]	A 048		

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A 048	Continued From page 73 This REQUIREMENT is not met as evidenced by: 7.8.2.48 C (2) NFPA 70 National Electric Code 210.8 Ground Fault Circuit Interrupter Protection for Personnel 210.8 (B) Other than dwelling units. All 125 volt, single phase, 15 and 20 ampere receptacles installed in the locations specified in 210.8 (B)(1) through (8) shall have ground fault circuit interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception 1: to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow melting, de-icing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22 as applicable. Exception 2: to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2)shall be permitted for only those receptacles outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 6 ft. of the outside edge of the sink. Exception 1 to (5): In industrial laboratories,	A 048		

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A 048	Continued From page 74 receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. Based on observation and interview, the facility failed to ensure that: 1. Only approved U/L (Underwriter Laboratories APPROVED) surge protectors with integrated circuit breaker no greater than 6 feet in length were used for the intended purpose (Computer electronics only) and not as an extension cord. 2. The Ground Fault Circuit Interrupter (GFCI) protectors by the sinks in all bathrooms, were in working order. 3. The washing machine (located in the bathroom) was plugged directly into a GFCI outlet. 4. The dryer was plugged directly into a GFCI outlet, not a surge protector being used as an extension cord. This deficient practice has the potential for all 16 (R #s 1-16) residents identified on the resident census list provided by the Administrator on 04/26/17, to be at risk of harm or death from an electric shock if water was to come in contact with electricity or if circuits become overloaded and a fire occurs. The findings are: Findings related to the use of outlet adapters:	A 048		

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A 048	Continued From page 75 A. On 04/25/17 at 11:12 am, during observation of room #4, the television (tv) was observed to be plugged in to a multi-plug outlet adapter (use not allowed) instead of directly into the wall. B. On 04/25/17 at 11:43 am, during observation of room #10, the tv and computer were observed to be plugged in to a multi-plug outlet adapter instead of directly into the wall. Findings related to GFCI outlets (including washer/dryer): C. On 04/25/17 at 2:18 pm, during observation of Bathroom #2, the GFCI outlet was observed to not be functioning correctly (would not trip when tested). D. On 04/25/17 at 2:25 pm, during observation of Bathroom #1 (with washer), the following was observed: 1. The GFCI outlet next to sink was not functioning correctly (would not light up on tester, would not reset). 2. The washer was was not plugged into a GFCI outlet. E. On 04/25/17 at 2:23 pm, during observation of the medication room the clothes dryer was observed to be plugged into a surge protector and not directly into a GFCI outlet. F. On 04/25/17 at 2:57 pm, during interview with Direct Care Staff (DCS) #1, she confirmed that: 1. The the TV's and computer in Room #s 4 and 10 were plugged into multi-plug wall outlet adapters (not allowed) and not plugged directly into the wall outlet. 2. The GFCI protectors by the sinks in all bathrooms, were not in working order.	A 048		

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A 048	Continued From page 76 3. The washing machine (located in the bathroom) was not plugged directly into a GFCI outlet. 4. The dryer was plugged into a surge protector and not directly into a GFCI outlet.	A 048		
A 049	7 NMAC 8.2.49 Doors DOORS: A. No door in any means of egress shall be locked against egress when the building is occupied. (1) Exit doors may be provided with a night latch, dead bolt, or security chain, provided these devices are operable from the inside, by any occupant, without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed forty-eight (48) inches above the finished floor. (2) If locks are not readily operable by all occupants within the building, the locks must: 1) unlock upon activation of the fire detection or sprinkler system and 2) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written approval from the building, fire and licensing authorities having jurisdiction. B. All exit doors shall have a minimum width of thirty-six (36) inches. (1) Facilities with a capacity of ten (10) or more residents shall have exit doors leading to the outside of the facility that open outward. (2) Facilities with a capacity of fifty (50) or more residents must provide panic hardware at the exit doors. (3) No door or path of travel to a means of egress shall be less than twenty-eight (28) inches wide. C. All resident sleeping room doors must be at least one and three-quarters (1 3/4) inch solid	A 049		

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A 049	Continued From page 77 core construction. D. Bathroom doors may be twenty-four (24) inches wide. Facilities with four (4) or more residents shall have at least one bathroom for every eight (8) residents with a door clearance of thirty-six (36) inches for access by persons with disabilities. E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside. F. All doors shall readily open from the inside. G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms. [7.8.2.49 NMAC - Rp, 7.8.2.50 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.49 A (1) (2) Based on observation and interview the facility failed to ensure that 2 of 2 exit doors could readily be opened from the inside by all occupants when locked. This deficient practice has the potential for all 16 (R #s 1-16) residents listed on the resident census list, provided by the Administrator on 04/26/17, to be at risk of injury, illness, or death if the exit doors are locked and residents cannot readily open them (with 1 motion) in the event of a fire, loss of power, or an emergency that requires evacuation. The findings are: Findings related to exit doors A. On 04/25/17 at 10:53 am, during observation of the dining room exit door it was observed that: 1. Both the deadbolt and button lock in the door handle were locked and had a sign on the door stating "KEEP DOOR LOCKED AT All TIMES" and a notice asking	A 049		

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A 049	Continued From page 78 staff/residents/visitors "PLEASE LEAVE THE DOOR LOCKED AT ALL TIMES (TOP and BOTTOM)". 2. When locked the door was not able to be opened by all occupants with one motion. B. On 04/25/17 at 11:08 am, during interview with Direct Care Staff (DCS) #1, she confirmed that: 1. The dining room exit door was locked (both deadbolt and button lock) and that there was a sign and notice on the door asking that staff/residents/visitors keep the door locked at all times (both top and bottom). 2. When locked the door was not able to be opened by all occupants with one motion. C. On 04/25/17 at 10:57 am, during observation of the front entrance exit door it was observed to have a button lock that does not release with one motion. D. On 04/25/17 at 11:08 am, during interview with DCS #1, she confirmed that the front exit door has a button lock that cannot be opened by all occupants with one motion. Findings related to bathroom #2 door. E. On 04/25/17 at 3:50 pm, during observation the door handle on the bathroom #2 door was loose and had a button lock that would not open with one motion. F. On 04/25/17 at 3:54 pm, during interview with DCS #1, she confirmed that the door handle on the bathroom #2 door was loose and had a button lock that would not open with one motion. Findings related to hot water closet door.	A 049		

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A 049	Continued From page 79 G. On 04/25/17 at 1:39 pm, during observation of the water heater closet door it was observed to have a broken hinge and did not open/close easily. H. On 04/25/17 at 1:41 pm, during interview with DCS #1, she confirmed the hot water heater closet door had a broken hinge and does open/close easily.	A 049		
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	A 055		

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A 055	Continued From page 80 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. 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 K Based on observation and interview the facility failed to ensure that the resident bathrooms were kept clean, sanitary, in good repair, free of germs/bacteria, insects, and available for use at any time. This deficient practice has the potential to negatively affect the health and safety of all 16 (R #s 1-16) residents identified on the resident census list provided by the Administrator on 04/26/17, if the bathrooms are contaminated with germs/bacteria, insects, used for storage/cleaning, and/or not available for use at anytime. The findings are: A. On 04/25/17 at 2:33 pm, during observation of Bathroom #3 the following was observed: 1. The shower/bathtub was being used as storage for the mop, mop bucket, and cleaning supplies. 2. Very dirty and bug infested windows 3. Spider webs on the walls	A 055		

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A 055	Continued From page 81 4. Dirty AC vents/sprinkler heads 5. Missing tiles on shower/bathtub walls 6. Multiple drywall penetrations in walls of the bathroom. B. On 04/25/17 at 2:57 pm, during observation and interview with Direct Care Staff (DCS) #1, she confirmed for Bathroom #3 that: 1. The shower/bathtub was being used as storage for the mop, mop bucket, and cleaning supplies. 2. Very dirty and bug infested windows 3. Spider webs on the walls 4. Dirty AC vents/sprinkler heads 5. Missing tiles on shower/bathtub walls 6. Multiple drywall penetrations in walls of the bathroom.	A 055		
A 061	7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: A. Fire alarm system. Facilities with four (4) or more residents shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction. B. Smoke and heat detection. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining and living room(s) must also be provided with smoke detectors. (1) Detectors shall be powered by the house electrical service and have battery back up. (2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas	A 061		

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A 061	Continued From page 82 and in each sleeping room. (3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service. [7.8.2.61 NMAC - Rp, 7.8.2.60 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.61 A NFPA 101, 2012 Edition 7.9.3 Periodic Testing of Emergency Lighting Equipment. 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	A 061		

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A 061	Continued From page 83 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 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	A 061		

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A 061	Continued From page 84 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 record review, observation, and interview the facility failed to ensure that: 1. The emergency lighting was tested annually for ninety (90) minutes. 2. The fire alarm circuit breaker is mechanically protected from being inadvertently turned to the "off" position. This deficient practice has the potential for all 16 (R #s 1-16) residents listed on the resident census list, provided by the Administrator on 04/26/27, to be at risk of harm or death if the: 1. Emergency lights do not stay on during evacuation in case of fire. 2. Circuit breaker for the the fire alarm system inadvertently is turned off and causing it to not operate properly and warn residents/staff if a fire were to occur. The findings are:	A 061		

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A 061	Continued From page 85 Findings related to emergency lighting. A. Record review request revealed no documentation that the emergency lighting system was tested annually for a minimum of ninety (90) minutes. B. On 04/26/17 at 2:47 pm, during interview with the Administrator, she confirmed that they had not been conducting an annual 90-minute test of the emergency lighting system. Findings related to fire alarm circuit breaker: C. On 04/25/17 at 1:55 pm, during observation the circuit breaker for the Fire Alarm System revealed it was not mechanically protected to prevent the alarm system from being inadvertently turned off. D. On 04/28/17 at 10:25 am, during interview with the Administrator, she confirmed that the circuit breaker for the Fire Alarm System was not mechanically protected to prevent the alarm system from being inadvertently turned off and causing the fire alarm system to not operate properly if a fire were to occur.	A 061		
A 069	7 NMAC 8.2.69 Memory Care Units MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions: The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply.	A 069		

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A 069	Continued From page 86 (1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer ' s gets progressively worse and is fatal. (2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services. (3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain. (4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program. (5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit. B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process. (1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services. (2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside	A 069		

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A 069	Continued From page 87 health care provider. C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information. D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria: (1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs; (2) medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. E. Assessments and reevaluations. (1) An assessment shall be completed by a registered nurse or a physician extender within	A 069		

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A 069	Continued From page 88 fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5) days after admission. (a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission. (b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit. (c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted. (2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident ' s stay in the assisted living facility memory care unit is still appropriate. F. Documentation in the resident ' s record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record: (1) the physician ' s diagnosis for admission to a secure environment or a memory care unit; (2) the pre-admission assessment; and (3) the re-evaluation(s).	A 069		

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A 069	Continued From page 89 G. Secured environment. (1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to: (a) double alarm systems; (b) gates connected to the fire alarm; and (c) tab alarms for residents at risk for elopement. (2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents. (a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident ' s legal representative,	A 069		

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A 069	Continued From page 90 if applicable and prior to the resident ' s admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for. (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: Reference 7.8.2.69 C Based on record review and Interview the facility failed to ensure that 1 (DCS #1) of 4 (DCS #s 1-4) Direct Care Staff whose training files were reviewed for compliance had received 12 hours of training per year related to dementia/Alzheimer's disease (memory loss) or other pertinent information. This deficient practice has the potential to cause those residents with dementia to not receive the specialized care to meet the individual needs (physical, mental, social, etc) of each resident with dementia to maintain the highest level of quality of life possible because staff does not have the required training. The findings are: A. Record review of DCS #1's training file	A 069		

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A 069	Continued From page 91 revealed no documentation that she received the required 12-hours of Dementia Care training in 2016. B. On 04/26/17 at 1:02 pm, during interview with the Administrator, she confirmed that DCS #1 had not received the required 12-hours of Dementia Care training in 2016.	A 069		
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 D, E, F	A 070		

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A 070	Continued From page 92 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 reasonably and completely search the registry, including the name, address, date of birth, social	A 070		

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(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 070	Continued From page 93 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. [7.1.12.8 NMAC - N, 01/01/2006]	A 070		

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	2109	A. BUILDING: _____ B. WING _____	C 04/28/2017

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A 070	Continued From page 94 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 mandatory processing fee with no exceptions.	A 070		

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A 070	Continued From page 95 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 providers shall maintain evidence of each	A 070		

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A 070	Continued From page 96 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 for 4 Direct Care Staff (DCS #s 1-4) of 4 (DCS #s 1-4) staff files reviewed for compliance that the: 1. Employee Abuse Registry (EAR) clearances were received prior to hire. 2. The application and fingerprints were submitted within twenty (20) days of hire. 3. Documentation/proof of the applications, fingerprints, and clearances were maintained and available for review. This deficient practice has the potential to affect the safety and welfare for all residents if their care and services are being provided by staff with a previous history of abusing, neglecting, or exploiting residents and/or has a felony conviction. The findings are: A. Record review of the Consolidated Online Registry (COR) report for DCS #1 (hire date 08/09/11) dated 09/09/11, revealed that her EAR clearance was not submitted/received prior to	A 070		

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A 070	Continued From page 97 hire. B. Record review of the COR report for DCS #1 (hire date 08/09/11) dated 09/09/11, revealed that her CCHSP application and fingerprints were not submitted within twenty (20) days after hire. C. On 04/28/17 at 1:02 pm, during interview with the Administrator, she confirmed that the COR (EAR/CCHSP) dated 09/09/11 for DCS#1 was not completed prior to hire and within twenty (20) days of hire. D. Record review of DCS #2's Final Registry Report, dated 07/29/16 revealed that her EAR clearance was not received prior to her hire date of 07/11/16. E. On 04/28/17 at 1:02 pm, during interview with the Administrator, she confirmed that the EAR clearance for DCS #2's was not received prior to her hire date of 07/11/16. F. Record review of DC'S #3's Final Registry Report, dated 04/12/17 revealed that her EAR clearance was not received prior to hire date of 03/27/17. G. On 04/28/17 at 1:02 pm, during interview with the Administrator, she confirmed that the EAR clearance for DC'S #3's was not received prior to her hire date of 03/27/17. H. Record review of DC'S #4's (hire date 01/16/17) resident file revealed no documentation of a COR or Final Registry Report to know when/if the EAR was submitted prior to hire and/or the CCHSP application and fingerprints were submitted within 20-days of hire.	A 070		

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A 070	Continued From page 98 I. On 04/28/17 at 1:02 pm, during interview with the Administrator, she confirmed that there is not a COR or Final Registry Report for DCS #4 showing dates of when the EAR/CCHSP applications/clearances were submitted and/or received available for review. Findings for Incident Reporting. 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W, 8 B (2), 10 C 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	A 070		

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A 070	Continued From page 99 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. C. All licensed health care facilities shall conduct a complete investigation and report the actions taken and conclusions reached by the facility within five (5) days of discovery of the incident. 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W, 8 B (2), 10 C 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	A 070		

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A 070	Continued From page 100	A 070		

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.

C. All licensed health care facilities shall conduct a complete investigation and report the actions taken and conclusions reached by the facility within five (5) days of discovery of the incident.

Based on record review and interview the facility failed to ensure for 1 of 1 self reported incident of exploitation of a resident by a Direct Care Staff (DCS), that they submitted documentation of the internal investigation within 5 business days after the incident occurred to the Licensing Authority. If the facility does not submit a five (5) day follow-up investigation report to the Licensing Authority then all 16 (R #s 1-6) residents listed on the census, provided by the Administrator on 04/26/17, may be at risk of being exploited if there is no oversite by the Licensing Authority to ensure that a thorough investigation has been completed and what precautions/interventions have been implemented to ensure future occurrences. The findings are:

A. Record request of the facility's follow-up investigation report submitted to the Licensing Authority within five (5) business days following the incident of exploitation of a Resident (R #1) a former Direct Care Staff (DCS #4), revealed no documentation of an internal investigation being conducted or a follow-up investigation report being submitted to the Licensing Authority.

B. On 04/26/17 at 1:35 pm, during interview with

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A 070	Continued From page 101 the Administrator, she confirmed that the facility did not submit a follow-up investigation report with in five (5) business days after the incident occurred to the Licensing Authority.	A 070		