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	4012	A. BUILDING: _____ B. WING _____	C 11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE SPIRE ASSISTED LIVING OF NORTH ALBUQ AC	7500 OAKLAND AVE NE ALBUQUERQUE, NM 87113

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A 000	Initial Comments Deficencies were cited during a Complaint survey completed on 11/22/17 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint Intake NM#30402 was unsubstantiated with deficiencies cited.	A 000		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures;	A 017		

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A 017	Continued From page 1 (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 C 7 Based on record review and interview the facility failed to ensure that 3 (House Manager (HM) and DCS #s 4 and 5) of 3 (HM and DCS #s 4 and 5) Direct Care Staff whose training files were reviewed for compliance received orientation and annual training in the Incident Reporting requirements for abuse, neglect, and exploitation. This deficient practice has the potential for residents to be at risk of being abused, neglected, and/or exploited if the staff have not been trained on how and what incidents need to be reported. The findings are: A. Record review of the House Manager's (Hire Date 08/23/06) Orientation/Annual Training records (Due 07/12/17) revealed, no documentation that he received training on the requirements of incident reporting. B. Record review of DCS #4's (Hire Date 06/16/17) Orientation Training records (Due 06/30/17) revealed, no documentation that she	A 017		

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A 017	Continued From page 2 received training on the requirements of incident reporting. C. Record review of DCS #5's (Hire Date 10/02/17) Orientation Training records (Due 10/15/17) revealed, no documentation that she received training on the requirements of incident reporting. D. Record review of the facility's Orientation/Annual Training form (not dated) revealed, it does not include a training on the requirements of incident reporting. E. On 11/22/17 at 10:35 am, during interview with the House Manager, he confirmed that neither he and DCS #s 4 and 5 received training on Incident Reporting during their Orientation/Annual training. He also confirmed that the facility's Orientation/Annual training form does not include training on the requirements of incident reporting.	A 017		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of	A 020		

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payment;
(5) the refund provision in case of death, transfer, voluntary or involuntary discharge;
(6) information to formulate advance directives;
(7) a written description of the legal rights of the residents translated into another language, if necessary;
(8) the facility's staffing ratio;
(9) written authorization for staff to assist with medications;
(10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC;
(11) the facility ' s bed hold policy; and
(12) the admission agreement may be terminated if an appropriate placement is found for the 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

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A 020	Continued From page 4	A 020		

in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and
(14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents.
B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following:
(1) ventilator dependency;
(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

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A 020	Continued From page 5 is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) 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.	A 020		

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A 020	Continued From page 6 D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) (9) (12) C (1) (2) D (1) Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy	A 020		

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

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

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

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

Refer to 7.8.2.20 A (5) (12); and
Senate Bill 0335 - 2013.

Based on record review and interview, the facility failed to ensure that:

1. The Admission/Discharge Agreement

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A 020	Continued From page 8 stated that the the agreement could be terminated "if" an appropriated placement had been found for the resident. 2. Refund upon Death policy in the agreement complies with 2013 state statue and revised regulation on "Limits of Charges after Resident Death." 3. The Admission/Discharge agreement includes a "Permission to Assist with Medication" form that incorrectly states that the Direct Care Staff (DCS) "will administer medications as delegated by a Licensed Health Care Professional according to the service plan" The DCS are only certified to assist with the self-Administration of medication. 4. That a team meeting was convened prior to admitting/retaining residents who have elected to receive hospice services and that their Individual Service Plans (ISP) have been updated to include coordination of care with the hospice provider. This deficient practice has the potential for all 24 (R #s 1-24) residents listed on the resident census, provided by the House Manager on 11/17/17, to be at risk of: 1. Having their Admission/Discharge Agreement termination and being discharged to an improper/unsafe environment. 2. The resident's estate or responsible party suffers financial hardship by not receiving the refund that is due upon the resident's death. 3. Being misinformed about the DCS's ability to administer medications. 4. DCS cannot provide the higher level of care the resident requires and/or the higher level of care needed places residents/staff at risk. 5. DCS do not know what care they need to provide and what care the hospice agency is providing.	A 020		

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A 020	Continued From page 9 The findings are: Findings related to Admission Agreements A. Record Review of R #1's Admission Agreement dated 03/04/17, revealed that it: 1. Does not state that the facility can terminate the agreement "If" an appropriate placement has been found for the resident. 2. Incorrectly states "The Contract Rate will be charged for the entire calendar month regardless of what portion of the month your unit is occupied" and does not comply with the 2013 revised regulation regarding "Limits of Charges after Resident Death". 3. The agreement did not include a "Permission to Assist with Medication" form for review. B. Record Review of R #2's Admission Agreement dated 05/29/17, revealed that it: 1. Does not state that the facility can terminate the agreement "If" an appropriate placement has been found for the resident. 2. Incorrectly states "The Contract Rate will be charged for the entire calendar month regardless of what portion of the month your unit is occupied" and does not comply with the 2013 revised regulation regarding "Limits of Charges after Resident Death". 3. Incorrectly states on the "Permission to Assist with Medication" form that the DCS (certified only to assist with the self-Administration of medication) will administer medications as delegated by a Licensed Health Care Professional according to the service plan. C. Record review of R #3's Admission Agreement dated [redacted]/17, revealed that it: 1. Does not state that the facility can	A 020		

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terminate the agreement "If" an appropriate placement has been found for the resident.

2. Incorrectly states "The Contract Rate will be charged for the entire calendar month regardless of what portion of the month your unit is occupied" and does not comply with the 2013 revised regulation regarding "Limits of Charges after Resident Death".

3. The agreement did not include a "Permission to Assist with Medication" form for review.

D. Record Review of R #4's Admission Agreement dated [redacted]/17, revealed that it:

1. Does not state that the facility can terminate the agreement "If" an appropriate placement has been found for the resident.

2. Incorrectly states "The Contract Rate will be charged for the entire calendar month regardless of what portion of the month your unit is occupied" and does not comply with the 2013 revised regulation regarding "Limits of Charges after Resident Death".

3. Incorrectly states on the "Permission to Assist with Medication" form that the DCS (certified only to assist with the self-Administration of medication) will administer medications as delegated by a Licensed Health Care Professional according to the service plan.

E. Record Review of R #5's Admission Agreement dated [redacted]/17, revealed that it:

1. Does not state that the facility can terminate the agreement "If" an appropriate placement has been found for the resident.

2. Incorrectly states "The Contract Rate will be charged for the entire calendar month regardless of what portion of the month your unit is occupied" and does not comply with the 2013 revised regulation regarding "Limits of Charges

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A 020	Continued From page 11 after Resident Death". 3. Incorrectly states on the "Permission to Assist with Medication" form that the DCS (certified only to assist with the self-Administration of medication) will administer medications as delegated by a Licensed Health Care Professional according to the service plan. F. Record review of R # 9's Admission Agreement dated [redacted]/17, revealed that it: 1. Does not state that the facility can terminate the agreement "If" an appropriate placement has been found for the resident. 2. Incorrectly states "The Contract Rate will be charged for the entire calendar month regardless of what portion of the month your unit is occupied" and does not comply with the 2013 revised regulation regarding "Limits of Charges after Resident Death". 3. Incorrectly states on the "Permission to Assist with Medication" form that the DCS (certified only to assist with the self-Administration of medication) will administer medications as delegated by a Licensed Health Care Professional according to the service plan. G. On 11/21/17 at 2:16 pm, during interview with the House Manager, he confirmed the incorrect and missing information in R #s 1-5 and 9's Admission/Discharge agreements. Findings related to team meetings and coordination of care H. Record review of R #5's resident file revealed: 1. No documentation that a team meeting was convened prior to [redacted] admission to hospice services on [redacted]/17. 2. There was no [redacted] available for review for coordination of care with the hospice provider.	A 020		

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A 020	Continued From page 12 I. Record review of R # 9's resident file revealed: 1. No documentation that a team meeting was convened prior to [redacted] admission to hospice services on [redacted]/17. 2. That the ISP did not include coordination of care with hospice provider. J. On 11/21/17 at 2:16 pm, during interview with the House Manager, he confirmed that there was no team meeting convened prior to being admitted to hospice and there was no coordination of care included in the ISP's for R #s 5 and 9.	A 020		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care	A 021		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 021	Continued From page 13 physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements	A 021		

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	4012	A. BUILDING: _____ B. WING _____	C 11/22/2017

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A 021	Continued From page 14 observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of	A 021		

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A 021	Continued From page 15 request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.21 A, B Based on record review, observation, and interview, the facility failed to ensure for 6 (R #s 1-5 and 9) of 6 (R #s 1-5 and 9) residents whose charts were reviewed for compliance were complete and maintained in an organized manner. This deficient practice could result in a delay in care or resident harm if the residents' charts are not complete and kept in an organized manner so that important medical and personal information is readily accessible to staff and medical professionals. The findings are: A. Record Review of R #s 1-5 and 9's Resident Charts revealed that they were not complete, had missing information and were located in different individual files and binders (white binder, brown file). B. Record review of R #1's Resident Charts revealed it did not include the following: 1. Allergy information. 2. Physician name/contact information on the face sheet. 3. History & Physical/Discharge orders. 4. Personal Demographic Information: a. Marital status.	A 021		

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A 021	Continued From page 16 b. Religion. c. Sex d. Dentist e. Social History 5. History & Physical/Discharge orders. C. Record review of R #2's Resident Charts revealed they did not contain the following information: 1. Face sheet-no physician contact information. 2. History & Physical D. Record review of R #3's Resident Charts revealed the following missing information: 1. Face Sheet: a. No move in/Admission date b. No diagnosis c. No allergy information (physician's assessment states resident is allergic to Penicillin). d. No diet information e. No assistive device information f. No Physician name/contact information 2. No History & Physical 3. The following demographic information: a. Martial status b. Religion c. Sex d. Dentist. e. Social History f. Language spoken/understood 4. No progress notes from Home Health Agency. 5. No Individual Service Plan (ISP) was available for review. E. Record Review of R #4's Resident Charts revealed the following missing information: 1. Face sheet	A 021		

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A 021	Continued From page 17 a. No previous address. b. No contact information for physician 2. Resident Demographics-not completed 3. ADL-assessment-not completed 4. Physician Orders/TB-not completed 5. Physician Assessment-not signed/dated by physician. F. Record Review of R #5's Resident Charts revealed the following missing information: 1. No Face Sheet 2. Resident Demographics incomplete a. Addresses, relationship and phone numbers of family members, or surrogate decision makers and other emergency contact person. b. Personal physician. c. Dentist d. Language spoken and understood; e. required diet information. 3. Physician Orders-not completed. 4. No physician name/contact information. 5. No ISP G. Record Review of R #9's Resident Charts revealed that there was no physician name and contact information on face sheet. H. On 11/21/17 at 10:26 am, during observation of the residents charts (white binder, brown folder) it was observed that the required documents were either missing or incomplete. The documents were observed to be in several different places and very disorganized. I. On 11/21/17 at 2:16 pm, during interview with the House Manager, he confirmed the missing/incomplete Resident Charts for R #s 1-5 and 9. In addition, he confirmed that the required resident documents were in several different	A 021		

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A 021	Continued From page 18 places and very disorganized.	A 021		
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained; (7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction; (8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks; (9) record of monthly fire drills conducted at the	A 022		

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A 022	Continued From page 19 facility and the fire safety evaluation system (FSES) rating, if applicable; (10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of emergencies: (a) an emergency that affects just the facility; and (b) a region/area wide emergency; (11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC); (12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and (13) vaccination records for pets in the facility. B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority: (1) a copy of the facility license; (2) employee personnel records, including an application for employment, training records and personnel actions: (a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC; (b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and (3) a copy of all waivers or variances granted by	A 022		

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A 022	Continued From page 20 the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas; (7) accommodation of resident ' s pets; and (8) resident use of electric blankets and appliances. D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas: (1) actions to be taken in case of accidents or emergencies; (2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission; (3) policy for medication errors; (4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.); (5) the handling of resident's funds, if the facility provides such services; (6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with	A 022		

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A 022	Continued From page 21 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (12) admission agreement; (13) admission records; (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010]	A 022		

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A 022	Continued From page 22 This REQUIREMENT is not met as evidenced by: 7.8.2.22 B (2) (a) (b) Based on record review and interview, the facility failed to ensure for 3 (HM and DCS #s 4 & 5) of 3 (HM and DCS #s 4 & 5) House Manager and Direct Care Staff whose staff files were reviewed for compliance were at the facility, available for review, and included the Employee Abuse Registry (EAR) and Criminal Caregivers History Screening Program (CCHSP) clearances with all required documents. This deficient practice has the potential for residents residing at the facility to be cared for by staff who do not meet the minimum qualifications and have a history of abusing, neglecting, and exploiting individuals providing their care. The findings are: A. Record request for the HM and DCS #s 4 & 5 revealed that the staff files including the EAR and CCHSP clearances were not maintained on site at the facility and immediately available for review. B. On 11/22/17 at 10:35 am, during interview with the House Manager, he confirmed that none of the staff files including the EAR and CCHSP clearances were maintained on site at the facility and immediately available for review.	A 022		
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	A 025		

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A 025	Continued From page 23	A 025		

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;
(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

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A 025	Continued From page 24 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 A B Based on record review and interview the facility failed to ensure for 4 (R #s 1 and 3-5) of 6 (R #s 1-5 and 9) residents whose evaluations/assessments were reviewed for compliance were: 1. Completed within 15-days prior to admission. 2. Reviewed and/or updated at a minimum of every 6-months. 3. Reviewed and/or updated when a change in condition occurred. This deficient practice has the potential to result in a delay in care, services, and assistance the residents may need due to a change in condition, resulting in possible complications and the need for medical intervention. The findings are:	A 025		

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A 025	Continued From page 25 Findings related to R #1 A. Record review of R #1's Evaluation/Assessment dated 02/16/17 revealed it: 1. Was not completed within 15-days prior to [redacted] admission to the facility on [redacted]/17. 2. Had not been updated at a minimum of every 6 months (Date Due 07/15/17) and was 4 months past due. B. On 11/21/17 at 2:16 pm, during interview with the House Manager, he confirmed that R #1's evaluation/assessment was not completed within 15-days prior to [redacted] admission on [redacted]/17 and had not been updated at a minimum of every 6 months (Date Due 07/15/17) and was 4 months past due. Findings related to R #3 C. Record review of R #3's Evaluation/Assessment dated 12/15/16 revealed that it had not been reviewed and/or updated within 15 days prior to [redacted] actual admission to the facility on [redacted]/17 and at a minimum of every 6 months (Date Due [redacted]/17) and there has been no assessment completed since [redacted] admission on [redacted]/17. D. On 11/21/17 at 2:16 pm, during interview with the House Manager, he confirmed that R #3's Evaluation/Assessment had not been updated within 15 days prior to [redacted] actual admission to the facility on [redacted]/17 and at a minimum of every 6 months (Date Due [redacted]/17) and there has been no assessment completed since [redacted] admission on [redacted]/17. Findings related to R #4	A 025		

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A 025	Continued From page 26 E. Record review of R #4's Evaluation/Assessment dated 02/15/17 revealed it had not been reviewed and /or updated at a minimum of every 6 months (07/15/17) and was 4 months past due. F. On 11/21/17 at 2:16 pm, during interview with the House Manager, he confirmed that R #4's Evaluation/Assessment had not been updated since 02/15/17 and was past due (4 months). Findings related to R #5 G. Record review of R #5's Evaluation/Assessment dated 05/22/17 revealed it was not reviewed or updated when [redacted] had a change of condition and was admitted to hospice on [redacted]/17. H. On 11/21/17 at 2:16 pm, during interview with the House Manager, he confirmed that R #5's Evaluation/Assessment had not been updated when [redacted] had a change in condition and was admitted to hospice [redacted]/17.	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	A 026		

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	4012	A. BUILDING: _____ B. WING _____	C 11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE SPIRE ASSISTED LIVING OF NORTH ALBUQ AC	7500 OAKLAND AVE NE ALBUQUERQUE, NM 87113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 026	Continued From page 27 reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A B (3) (7) Based on record review and interview the facility failed to ensure for 6 (R #s 1-5 and 9) of 6 (R #s 1-5 and 9) residents whose Individual Service Plans (ISPs) were reviewed for compliance had	A 026		

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A 026	Continued From page 28	A 026		

been:
1. Completed within 10 days after admission.
2. Reviewed and/or updated at a minimum of every 6 months or when a change in condition occurred.
3. Included goals and expected outcomes.
4. Addressed who will provide the care and services.
5. Included coordination of care with the hospice agency.
6. Were signed as reviewed and/or updated by a Licensed Nurse (LN) or Physician Extender (PE).

These deficient practices have the potential for residents to not receive the appropriate care/assistance needed and to not achieve or maintain their highest level of mental or physical function if the:
1. ISPs are not completed within 10 days after admission so the Direct Care Staff (DCS) know what care and services they need to provide.
2. The ISPs are not reviewed and/or updated to reflect changes in condition and care/services.
3. DCS are not aware of what goals and outcomes are expected.
4. DCS do not know what care they need to provide and what care the hospice agency is providing.
5. The ISPs are not signed as reviewed and/or if needed updated at a minimum of every 6 months or when a change in condition occurred by a LN or PE.
The findings are:

A. Record review of R #1's [redacted] dated [redacted]/17 revealed it:
1. Had not been updated at a minimum of every 6-months (Date Due [redacted]/17) and was

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A 026	Continued From page 29 was 4 momths past due. 2. Did not include any goals or expected outcomes. 3. Did not address who will provide the care and services. B. Record review of R #2's [redacted]/17 revealed, it did not include any goals or expected outcomes or address who will provide the care and services. C. Record review of R #3's [redacted]/16 revealed, it was not updated within 10-days after admission on [redacted]/17 and had not been updated since [redacted] was admitted to the facility on [redacted]/17. D. Record review of R #4's [redacted]/17 revealed it: 1. Had not been updated at a minimum of every 6 months (Date Due [redacted]17). 2. Did not include any goals or expected outcomes. 3. Did not address who will provide the care and services. E. Record review of R #5's resident file (admission date [redacted]/17) revealed there was no ISP available for review. F. Record review of R #9's ISP (not dated) revealed it: 1. It did not include any goals or expected outcomes. 2: It did not address who will provide the care and services. 3. Did not include coordination of care with the hospice agency. 4. Not signed or dated as reviewed by nurse. G. On 11/22/17 at 2:16 pm, during interview with the House Manager, he confirmed the ISP	A 026		

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A 026	Continued From page 30 findings listed above for R #s 1-5 and 9. In addition he stated that he could not confirm if any [redacted] had been completed for R #3's (since 12/15/16) and R #5, because he was not the House Manager at that time.	A 026		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC,	A 032		

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A 032	Continued From page 31 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32. A B 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. 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	A 032		

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A 032	Continued From page 32 ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure that all incidents of suspected or known resident abuse, neglect, or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and others were reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. That an internal investigation was conducted and a follow-up report was submitted within 5 business days to the Licensing Authority. This deficient practice has the potential all 24 (R #s 1-24) residents listed on the resident census, provided by the House Manager on 11/17/17, to be at risk of being abused, neglected, and/or not receiving needed medical care and services if incidents are not being reported as required. If the facility is not conducting internal investigations and submitting their findings to the Licensing Authority, then residents are at risk of continued suffering and further injury if there is no oversite of the care and services the facility is providing. The findings are: Findings related to R #3 A. Record review of the facility's internal incident report dated 10/25/17, revealed that R #3 became combative when the Direct Care Staff (DCS) attempted to take [redacted] vitals and assist [redacted] with a shower. R #3 hit and scratched the DCS and threw [redacted] onto the floor (no-injury noted). There was no investigation documentation available for review that the incident was reported to the Licensing Authority within 24 hrs.	A 032		

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A 032	Continued From page 33 B. On 11/21/17 at 10:06 am, during interview with the House Manager, he confirmed that the 10/25/17 incident where R #3 was being combative (hitting/scratching) staff was not reported to the Licensing Authority within 24 hrs. C. Record review of the [name of hospital] After Visit Summary dated 04/02/17 revealed, a diagnosis of a "closed fracture of rib and fall from other, slipping, tripping, or stumbling." The x-ray (a photographic or digital image of the internal composition of something, especially a part of the body) results stated that she had to the "left lateral (relating to the side) eighth and ninth rib fractures." D. Record review of R #3's resident chart, revealed no documentation of a facility incident report being completed or submitted to the Licensing Authority within 24 hours or the next business day if a holiday or weekend after [redacted]/17. E. Record request for the DCS Task Sheet for R #3 dated [redacted]/17 [redacted] revealed that the document could not be found. F. On 11/21/17 at 8:06 am, during interview with the House Manager, he confirmed that at this time he could not find the DCS task sheet for [redacted]/17 [redacted] G. On 11/21/17 at 10:06 am, during interview with the House Manager, he stated that "there was no documentation of any incident reports (internal or state reportable) regarding R #3 having a [redacted] H. On 11/22/17 at 4:20 pm, during interview with the Administrator and House Manager, they both	A 032		

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A 032	Continued From page 34 stated that they had no knowledge of R #3 having [redacted]/17. The Administrator stated that "the [name of hospital] After Visit Summary may have been put in R #3's file by the former House Manager, who did not inform her of the incident and confirmed that the incident should have been reported to the Licensing Authority once the facility became aware of the R #3's [redacted] Findings related to R #4 I. Record review of the facility's internal incident report dated 10/30/17, revealed that R #4 had an [redacted] There was no investigative documentation to indicate that the the incident was reported to the Licensing Authority. J. On 11/21/17 at 10:25 am, during interview with the House Manager, he confirmed that R #4's unwitnessed fall with injury was not reported to the Licensing Authority within 24 hrs. Findings related to R #5 K. Record review of the facility's internal incident report dated 06/17/17, revealed that R #5 had made comments about a [redacted] DCS touching [redacted] There was no investigative documentation to indicate that the incident was reported to the Licensing Authority. L. On 11/21/17 at 10:25 am, during interview with the House Manager, he confirmed that there was no documentation that the 06/17/17 incident where R #5 commented that a [redacted] DCS touched [redacted] was reported to the Licensing Authority within 24 hrs.	A 032		

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A 032	Continued From page 35 Findings related to R #9 M. Record review of the facility's 5-day Investigation Follow-Up Report (11/06/17) for R #9's fall with injury on 11/04/17 revealed, it did not include: 1. A summary of the incident. 2. Documentation that an investigation of the incident was conducted. N. On 11/21/17 at 10:06 am, during interview with the House Manager he confirmed that the facility did not conduct an investigation when she had her falls. O. On 11/21/17 at 10:25 am, during interview with the House Manager, he confirmed that the incidents for R #s 3-5 and 9 were not reported to the Licensing Authority within 24 hrs.	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 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;	A 033		

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A 033	Continued From page 36 (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; (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	A 033		

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A 033	Continued From page 37 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 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	A 033		

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A 033	Continued From page 38 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: 7.8.2.33 D (4) Based on observation and interview the facility failed to provide a safe and sanitary environment by ensuring that soiled (feces and urine) linens were transported through the facility sealed in plastic bag and not exposed to the environment. This deficient practice has the potential for all 24 (R #s 1-24) residents listed on the resident census, provided by the House Manager on 11/17/17, to be at risk for illness or harm from infectious/contagious diseases if soiled linens are not transported in a safe and sanitary manner. The findings are: A. On 11/20/17 at 4:08 pm, during observation the House Manager was observed carrying soiled	A 033		

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A 033	Continued From page 39 [redacted] linens that had not been placed in a closed plastic bag/container from R #2's room, through the hallway and living area, to the laundry room. B. On 11/20/17 at 4:36 pm, during interview with the House Manager, he confirmed that he had carried the [redacted] linens that had not been placed in a closed plastic bag/container from R #2's room, through the hallway and living area, to the laundry room.	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	A 034		

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A 034	Continued From page 40 refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (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	A 034		

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A 034	Continued From page 41 pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall 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) (8) (b) B (2) Based on record review, observation, and	A 034		

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A 034	Continued From page 42 interview the facility failed to ensure: 1. The medication refrigerators had locks on them. 2. The temperature of the medication rooms and refrigerators were recorded daily. 3. The controlled drug record included the date and time the narcotic medication was given. 4. There was an accurate reconciliation of narcotic medications. These deficient practices have the potential for safety and welfare of all 24 (R #s 1-24) residents listed on the resident census, provided by the House Manager on 11/17/17, to be at risk if: 1. The medications are not kept in a locked refrigerator, then medications may be misused, or stolen. 2. The daily temperatures of the medication rooms and refrigerators are not recorded daily to ensure medications do not become spoiled, contaminated, and/or ineffective. 3. If there is no record of the date and time narcotic medications were given. 4. If there is not a accurate reconciliation of the narcotic medications to ensure they were received by the residents and not missing or stolen. The findings are: Findings related to missing and broken refrigerator locks A. On 11/22/17 at 11:36 am, during observation of the medication refrigerator in Nursing Station (NS #1), it was observed to not be locked. B. On 11/22/17 at 11:55 am, during interview with DCS #2, she confirmed that the medication refrigerator was not locked and stated that the lock was broken.	A 034		

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A 034	Continued From page 43 C. On 11/22/17 at 12:45 pm, during observation and interview of the medication refrigerator in NS #2, it was observed to not have a lock on it. The observation was confirmed by the House Manager. Findings related to medication room/refrigerators and daily temperature logs D. Record review of the November 2017 medication room/refrigerator temperature log for NS #1, revealed the last recorded temperatures were on 11/16/17. E. Record review of the August 2017 medication room/refrigerator temperature logs for NS #2, revealed the last recorded temperatures were on 08/31/17. There were no logs available for review for September, October, or November 2017. F. On 11/22/17 at 1:12 pm, during interview with the House Manager, he confirmed the medication room/refrigerator temperature findings for NS #s 1 and 2. Findings related to Narcotic shift change count sheets. G. Record review of the Controlled Medication Sign Sheet for Nursing Station (NS #1) dated 10/06/17 thru 11/22/17, revealed missing signatures for the DCS counting the narcotics on the following dates: 1. 10/10/17 at 7:55 am. 2. 10/15/17 at 7:20 pm. 3. 10/24/27 at 8:04 am. 4. 10/31/17 at 7:55 (am/pm-blank). 5. 11/05/17 at 7:40 pm. 6. 11/18/17 at 8:08 pm.	A 034		

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A 034	Continued From page 44 H. Record review of the Controlled Medication Sign Sheet for Nursing Station (NS #1) dated 10/06/17 thru 11/22/17, revealed missing signatures for the DCS witnessing the counting of the narcotics on the following dates: 1. 10/16/17 at 10:40 pm. 2. 10/20/17 at 7:02 am. 3. 10/21/17 at 10:09 pm. 4. 10/23/17 at 10:00 pm. 5. 10/27/17 at 10:10 pm. 6. 11/02/17 at 7:00 am. 7. 11/05/17 at 10:27 pm. 8. 11/06/17 at 7:23 am. 9. 11/07/17 at 7:45 am. 10. 11/07/17 at 11:30 (am/pm-blank) 11. 11/09/17 at 10:40 pm. 12. 11/10/17 at 7:07 am. 13. 11/12/17 at 7:55 pm. 14. 11/14/17 at 1:10 am. 15. 11/18/17 at 7:15 am. 16. 11/20/17 at 7:24 am. I. On 11/22/17 at 11:36 am, during interview with DCS #2, she confirmed the missing signatures of the DCS counting/witnessing the narcotic count on the Controlled Medication Sign Sheet for NS #1 dated 10/06/17 thru 11/22/17. J. On 11/22/17 at 12:17 pm, during interview with the HM, he confirmed that the missing DCS signatures on the Controlled Medication Sign Sheet for NS #1 dated 10/06/17 thru 11/22/17. Findings related to R #5 K. On 11/22/17 at 11:36 am, during observation of R #5's [redacted] it was observed to have 21 doses remaining.	A 034		

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A 034	Continued From page 45 L. Record review of R #5's Controlled Drug Record for [redacted] dated 09/21/17 thru 11/17/17 revealed there should be 18 doses remaining. M. On 11/22/17 at 11:45 am, during interview with DCS #2, she confirmed that the narcotic count sheet and the actual remaining for R #5's [redacted] did not match. N. Record review of R #5's Controlled Drug Record for [redacted] dated 09/21/17 thru 11/17/17 revealed that there should be 18 doses remaining. According to the Control Drug Record, she received the medication on 09/21/17, 09/22/17, 10/13/17, 10/16/17, 10/24/17, 11/3/17, 11/10/17, 11/17/17, and 4 doses with no date or time given listed for a total of 12 doses given. O. Record review of R #5's September, October, and November 2017 Medication Administration Records (MARs) revealed she received the medication on 09/21/17, 10/20/17, 10/24/17, 11/3/17, 11/10/17, 11/14/17, 11/17/17 for a total of 7 doses given. P. On 11/22/17 at 1:00 pm, during interview with the House Manager, he confirmed that the Controlled Drug Record, MARs, and actual amount remaining for R #5's [redacted] did not match and did not provide an accurate reconciliation of [redacted] medication.	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	A 035		

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A 035	Continued From page 46 over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the 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	A 035		

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A 035	Continued From page 47 licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (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	A 035		

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A 035	Continued From page 48 discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the 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.	A 035		

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A 035	Continued From page 49 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 A Based on observation and interview the facility failed to ensure for 1 (R #8) of 1 (R #8) resident observed to be actively dying and unable to physically/cognitively assist with the self-administration of her medications, that only a Licensed Nurse or Certified Health Care Provider administered the medications. This deficient practice has the potential for residents who cannot assist with the self-administration of their medications to be at risk of being harmed if their medications are administered by non-qualified staff. The findings are: A. On [redacted]/17 at 3:08 pm, during observation of the medication pass for R #8 [redacted] Direct Care Staff (DCS) #4 was observed placing	A 035		

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A 035	Continued From page 50 the [redacted] into R #8's mouth; administering [redacted] medication. B. On 11/20/17 at 3:11 pm, during interview with DCS #4, she confirmed that R #8 was unable to assist with the self administration of [redacted] medications (physically or cognitively) and that she (DCS #4) did administer the medications to R #8. DCS #4 confirmed that she is neither a Licensed Nurse or a Certified Health Care Professional licensed by the State Board of Nursing.	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 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;	A 036		

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A 036	Continued From page 51 (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; (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	A 036		

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A 036	Continued From page 52 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 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.	A 036		

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A 036	Continued From page 53 (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 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.	A 036		

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A 036	Continued From page 54 (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 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	A 036		

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A 036	Continued From page 55 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 C (5) Based on observation and interview the facility failed to ensure that the: 1. Dietary Staff (DS) wear hairnets or caps when preparing food for the residents. 2. Food is not stored in the medication refrigerator. This deficient practice has the potential for 24 (R #s 1-24) residents listed on the resident census, provided by the House Manager on 11/17/17, to be at risk of contracting foodborne illnesses if	A 036		

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A 036	Continued From page 56 they are being served food contaminated with bacteria. Residents are at risk of illness if their medication is contaminated by old/spoiled food and causing it to be ineffective. The findings are: A. On 11/21/17 at 8:21 am, during observation the DS was observed in the kitchen preparing food for the residents without a hairnet on. B. On 11/21/17 at 8:22 am, during interview with DS, she confirmed that she was not wearing a hairnet while preparing food for the residents. Findings related to unlocked dirty medication refrigerators. C. On 11/22/17 at 11:36 am, during observation of the medication refrigerator in Nurses Station #1, it was observed to be very dirty and to have old food in it. D. On 11/22/17 at 11:55 am, during interview with Direct Care Staff #2, she confirmed that the medication refrigerator was dirty and had old food in it. E. On 11/22/17 at 12:45 pm, during observation and interview with the House Manager, the medication refrigerator was observed to be dirty and had leftover food in it. The House Manager confirmed the observation.	A 036		
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 042		

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A 042	Continued From page 57 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 Based on observation and interview the facility failed to ensure that the electrical room was clean, free of safety hazards, had a straight access from entrance to panel, and working clearances of 36" (inches) in front of the panels and 30" to the sides were maintained at all electrical panels. This deficient practice has the potential for all 24 (R #s 1-24) residents listed on the resident census, provided by the House Manager on 11/17/17 to be at risk of illness, injury, and/or death if a fire or other emergency requiring immediate access to the electrical panel and the direct path and working area are not maintained. The findings are: A. On 11/17/17 at 11:29 am, during observation the electrical room was observed being used for storage and the circuit breaker boxes and electrical panels were observed to be blocked by wheelchairs, walkers, boxes, and other miscellaneous items preventing immediate access to them.	A 042		

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A 042	Continued From page 58 B. On 11/17/17 at 11: 29 am, during interview with Direct Care Staff (DCS) #1, she confirmed the observation that the electrical room was being used for storage and that the circuit breaker/electrical panels were blocked, preventing immediate access.	A 042		
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	A 049		

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A 049	Continued From page 59 least one and three-quarters (1 3/4) inch solid 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 F Based on observation and interview, the facility failed to ensure that the public restroom doors could be readily opened from the inside. This deficient practice has the potential for all 24 (R #s 1-24) residents listed on the census, provided by the House Manager on 11/17/17, to be at risk of harm, injury, or death if a fire or other emergency requiring evacuation were to occur and they became trapped and unable to get out of the bathroom to exit the building. The findings are: A. On 11/22/17 at 1:15 pm, during observation of public restroom next to the living room the door lock was observed to be hard to lock for privacy and would not not readily open when locked. The locking mechanism should release easily when the door knob is turned. B. On 11/22/17 at 1:16 pm, during interview with the House Manager, he confirmed that the door	A 049		

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A 049	Continued From page 60 lock on the door of the public restroom, next to the living room was hard to lock for privacy and would not readily open when locked. The locking mechanism should release easily when the door knob is turned. C. On 11/22/17 at 1:20 pm, during observation of the public restroom next to electrical room, the lock was observed to be hard to lock for privacy and would not readily open when locked. The locking mechanism should release easily when the door knob is turned. D. On 11/22/17 at 1:25 pm, during interview with the House Manager, he confirmed that the door lock on the door of the public restroom, next to the electrical closet was hard to lock for privacy and would not readily open when locked. The locking mechanism should release easily when the door knob is turned.	A 049		
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically	A 068		

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A 068	Continued From page 61 directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of	A 068		

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A 068	Continued From page 62 palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them. (3) 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 068		

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A 068	Continued From page 63 (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. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident	A 068		

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A 068	Continued From page 64 ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified. E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP;	A 068		

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A 068	Continued From page 65 (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.68 B (1) C (2) D (2) Based on record review and interview the facility failed to ensure that: 1, The Direct Care Staff (DCS) received 6-hours of hospice/palliative specific training annually. 2. A team meeting is convened prior to admitting/retaining residents who have chosen to receive hospice services. 3. The Individual Service Plans (ISPs) included documentation of coordination of care with the hospice provider. This deficient practice has the potential for 2 (R #s 5 and 9) of 3 (R #s 5 8 and 9) residents (current and former) identified by the House Manager on 11/17/17 as receiving hospice services to be at risk of not receiving the higher level of care and services needed if: 1. The (DCS) are not trained to provided that increased care services needed by residents on hospice.	A 068		

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A 068	Continued From page 66 2. If a team meeting was not convened to ensure the facility can provide the increased level of care needed. 3. If the DCS are not aware of what care/services the hospice provider will provide and what care/services they are to provide. The findings are: Findings related to training A. Record Review of the House Manager's (hire date 08/23/16) training file revealed, that he had not completed 6-hours of annual hospice/palliative care (specialized medical care for people with serious illness) specific training. B. On 11/22/17 at 10:35 am, during interview with the House Manager, he confirmed that he had not completed 6-hours of hospice/palative care specific training. Findings related to team meeting and ISPs C. Record review of R #5's resident file revealed: 1. No documentation that a team meeting was convened prior to [redacted] admission to hospice services [redacted]/27. 2. There was no documentation of an ISP available for review. D. Record review of R # 9's resident file revealed: 1. No documentation that a team meeting was convened prior to [redacted] admission to hospice services on [redacted]/17. 2. That the ISP (not dated) did not include coordination of care with hospice provider. E. On 11/21/17 at 2:16 pm, during interview with the House Manager, he stated that he just	A 068		

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	4012	A. BUILDING: _____ B. WING _____	C 11/22/2017

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A 068	Continued From page 67 recently became the House Manager for this facility and confirmed there was no documentation that a team meeting was convened prior to R #s 5 and 9 being admitted to hospice services. He also confirmed that there was no ISP available for review for R #5 and that the ISP for R #9 did not include coordination of care with [redacted] hospice provider.	A 068		
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 F	A 070		

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A 070	Continued From page 68 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure that all incidents of suspected or known resident abuse, neglect, or unusual occurrence which has or could threaten the	A 070		

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A 070	Continued From page 69	A 070		

health, safety, or welfare of the residents and others were reported to the Licensing Authority reported within 24 hours or the next business day if a weekend or holiday. That an internal investigation was conducted and a follow-up report was submitted within 5 business days to the Licensing Authority. This deficient practice has the potential all 24 (R #s 1-24) residents listed on the resident census, provided by the House Manager on 11/17/17, to be at risk of being abused, neglected, and/or not receiving needed medical care and services if incidents are not being reported as required. If the facility is not conducting internal investigations and submitting their findings to the Licensing Authority, then residents are at risk of continued suffering and further injury if there is no oversite of the care and services the facility is providing. The findings are:

Findings related to R #3

A. Record review of the facility's internal incident report dated 10/25/17, revealed that R #3 became combative when the Direct Care Staff (DCS) attempted to take [redacted] vitals and assist [redacted] with a shower. R #3 hit and scratched the DCS and threw [redacted] onto the floor (no-injury noted). There was no investigation documentation available for review that the incident was reported to the Licensing Authority within 24 hrs.

B. On 11/21/17 at 10:06 am, during interview with the House Manager, he confirmed that the 10/25/17 incident where R #3 was being combative (hitting/scratching) staff was not reported to the Licensing Authority within 24 hrs.

C. Record review of the [name of hospital] After Visit Summary dated 04/02/17 revealed, a diagnosis of a [redacted]

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A 070	Continued From page 70 [redacted] D. Record review of R #3's resident chart, revealed no documentation of a facility incident report being completed or submitted to the Licensing Authority within 24 hours or the next business day if a holiday or weekend after [redacted]/17. E. Record request for the DCS Task Sheet for R #3 dated [redacted]/17 [redacted] revealed that the document could not be found. F. On 11/21/17 at 8:06 am, during interview with the House Manager, he confirmed that at this time he could not find the DCS task sheet for 04/02/17 (day ribs broken). G. On 11/21/17 at 10:06 am, during interview with the House Manager, he stated that "there was no documentation of any incident reports (internal or state reportable) regarding R #3 [redacted] H. On 11/22/17 at 4:20 pm, during interview with the Administrator and House Manager, they both stated that they had no knowledge of R #3 having [redacted] prior to [redacted]/17. The Administrator stated that "the [name of hospital] After Visit Summary may have been put in R #3's file by the former House Manager, who did not inform her of the incident and confirmed that the incident should have been reported to the Licensing Authority once the facility became aware of the R #3's fall with injury."	A 070		

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A 070	Continued From page 71 Findings related to R #4 I. Record review of the facility's internal incident report dated 10/30/17, revealed that R #4 had an [redacted] There was no investigative documentation to indicate that the the incident was reported to the Licensing Authority. J. On 11/21/17 at 10:25 am, during interview with the House Manager, he confirmed that R #4's [redacted] with injury was not reported to the Licensing Authority within 24 hrs. Findings related to R #5 K. Record review of the facility's internal incident report dated 06/17/17, revealed that R #5 had made comments about a [redacted] DCS touching [redacted] There was no investigative documentation to indicate that the incident was reported to the Licensing Authority. L. On 11/21/17 at 10:25 am, during interview with the House Manager, he confirmed that there was no documentation that the 06/17/17 incident where R #5 commented that a [redacted] DCS [redacted] was reported to the Licensing Authority within 24 hrs. Findings related to R #9 M. Record review of the facility's 5-day Investigation Follow-Up Report (11/06/17) for R #9's fall with injury on 11/04/17 revealed, it did not include: 1. A summary of the incident. 2. Documentation that an investigation of the	A 070		

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A 070	Continued From page 72 incident was conducted. N. On 11/21/17 at 10:06 am, during interview with the House Manager he confirmed that the facility did not conduct an investigation when [redacted] O. On 11/21/17 at 10:25 am, during interview with the House Manager, he confirmed that the incidents for R #s 3-5 and 9 were not reported to the Licensing Authority within 24 hrs.	A 070		