

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  <b>ORIGINAL</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>2066</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/03/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PONCE DE LEON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE  <b>640 ALTA VISTA STREET SANTA FE, NM 87505</b>
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A17	<p>7 NMAC 8.2.17 Personnel</p> <p>7.8.2.17 PERSONNEL: The adult residential care facility must have and implement written personnel policies. The personnel policies must address the following:</p> <p>A. Qualifications for all professional and non-professional disciplines.</p> <p>B. Staff conduct which must foster resident safety and well-being and must not be detrimental to resident care.</p> <p>C. Staff training, appropriate to staff responsibilities, including, at a minimum, an orientation and an on-going, but at least annual, program which includes: Fire Safety, First Aid, Safe Food Handling practices, Confidentiality of Records and Resident information, Infection Control, Resident Rights, Reporting Requirements for Abuse, Neglect, and Exploitation, Transportation Safety for Assisting residents and operating vehicles to transport residents and Providing Quality Resident Care based on current resident needs.</p> <p>D. Employee personnel records, including an application for employment, TB tests and certificates, training records, and personnel actions.</p> <p>[4-7-97; 7.8.2.17 NMAC - Rn &amp; A, 7 NMAC 8.2.17, 8-31-00]</p> <p>This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.17(C) - Required On Going Staff Training</p> <p>Based on record review and interview, the facility failed to ensure ongoing training for 10 of 10 sampled employees.</p>	A17	<p><b>1. The violation will be corrected by immediate training of all applicable existing employees in any of the nine areas noted.</b></p> <p><b>2. The facility will identify other residents having the potential to be affected by the same deficient practice by an immediate survey of all personnel training records.</b></p> <p><b>3. The facility will monitor its corrective action by a monthly training record signed by the Health and Wellness Director and Executive Director and maintenance of monthly/yearly in-service records by the Health and Wellness Director and the Business Manager.</b></p> <p><b>4. The corrective action related to this deficiency will be completed by October 8, 2009.</b></p>	
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Division of Health Improvement

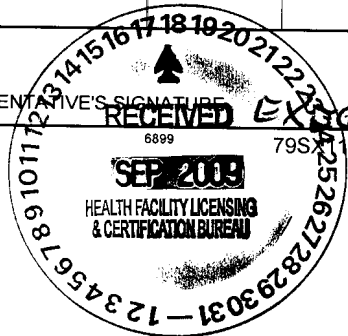
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

*EXECUTIVE DIRECTOR* **9/18/09**



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A17	Continued From page 1 The findings are: A. On 9/2/09 at 1:00 PM during review of the personnel and facility records, it was noted that there was no documentation of current required training for the following: 1. Fire Safety - Staff #1-6, 9, 10 1. First Aid - Staff #1-4, 6, 9, 10 2. Confidentiality of Records - Staff #1-10 4. Infection Control - Staff #3, 10 5. Resident Rights - Staff #1-10 6. Providing Quality Resident Care based on current resident needs - Staff #1-10 B. On 9/2/09 at 2:30 PM during an interview with the Health and Wellness Director, she acknowledged the finding.	A17		
A18	7 NMAC 8.2.18 Staffing The following staffing levels are minimums only. The facility shall employ staff capable and trained to provide the basic care and resident assistance and supervision required, based on the assessment of the residents needs. A. When residents are awake, all facilities shall have at least one (1) direct care staff person on duty and awake for each fifteen (15) residents. (1) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty and responsible for the care and supervision when residents are in the facility. (2) During resident sleeping hours, facilities with sixteen (16) to sixty (60) residents shall have at least one (1) direct care staff person awake at all times and at least one (1) additional staff person available on the premises. (3) During resident sleeping hours, facilities with sixty-one (61) to one-hundred	A18	<b>1. The violation will be corrected by strictly adhering to the state staffing requirements.</b> <b>2. The facility will identify other residents having the potential to be affected by the same deficient practice by an immediate review of schedules.</b> <b>3. The facility will monitor its corrective action by monthly review and sign off of direct care monthly schedules by the Health and Wellness Director and the</b>	

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A18	Continued From page 2  twenty (120) residents shall have at least two (2) direct care staff persons awake at all times and at least one (1) additional staff person immediately available on the premises when residents are sleeping.  (4) During resident sleeping hours, facilities with more than one-hundred twenty (120) residents shall have at least three (3) direct care staff persons awake at all times and one additional staff person immediately available on the premises for each additional forty (40) residents or fraction thereof in the facility.  B. The facility, upon request, shall provide the public and visitors the number and the names of all staff on duty.  C. Maternity Shelters shall have available at all times a registered nurse or a licensed midwife. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.2.8.18 NMAC - Rn, 7 NMAC 8.2.18, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.18 A - Staffing  Based on record review and interview the facility failed to ensure that staffing levels were met on a daily basis and met the Requirements for Adult Residential Care Facilities.  The findings are:  A. On 9/1/09 at 10:00 AM review of staff schedules for the Assisted Living portion of the community for August and September of 2009 revealed that the facility staff levels are not in compliance. More than half of the month there were 2 staff and the census was 44. Not meeting the 1 direct care staff per 15 residents.  B. On 9/1/09 at 4:00 PM during an interview with the Health and Wellness Director, she	A18	<b>Executive Director. Additionally the format of the direct care associate schedule has been modified to more clearly identify the number of direct care associates assigned to each shift.</b>  <b>4. The corrective action related to this deficiency will be completed by October 8, 2009.</b>	

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A18	Continued From page 3 acknowledged the finding.	A18		
A24	7 NMAC 8.2.24 Pets  7.8.2.24 PETS: Pets are permitted in a licensed facility, in accordance with the facility's rules. A. Pets are not permitted in the kitchen or food preparation areas. B. Pets shall be vaccinated in accordance with all state and local requirements and records of such vaccination shall be kept on file in the facility [7-11-86, 4-7-97; 7.8.2.24 NMAC - Rn, 7 NMAC 8.2.24, 8-31-00]  This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.24 (A)(B)- Pets  Based on record review and interview the facility failed to have records of pet vaccinations for 4 of 4 assisted living residents.  A. On 9/2/09 at 2:30 PM during a review of facility records revealed there were no pet vaccination records on file at the facility for pets living in Room 120, 130, 132, 223, .  B. On 9/2/09 at 2:45 PM an during interview with Resident Services Director, he acknowledged the finding.	A24	<p><b>1. The violation will be corrected by an immediate identification of all pets in licensed apartments. All pet vaccination documentation, of pets residing in licensed apartments, will be maintained by the Health and Wellness Director.</b></p> <p><b>2. The facility will identify other residents having the potential to be affected by the same deficient practice by a daily survey of direct care employees of any new pets in assisted living.</b></p> <p><b>3. The facility will monitor its corrective action by a duplicate log of all new pets residing in the facility maintained by the Resident Services Director.</b></p> <p><b>4. The corrective action related to this deficiency will be completed by October 8, 2009.</b></p>	
A36	7 NMAC 8.2.36 Medications  7.8.2.36 MEDICATIONS: Medications will be administered or staff assistance with medications provided and documented in accordance with state and federal laws.	A36	<p><b>1. The violation will be corrected by all assisted living residents, resident's guardian, treatment guardian or surrogate</b></p>	

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A36	Continued From page 4  A. Licensed health care professionals are responsible for the administration of medications. B. Facility staff may assist a resident with medications if written consent by the resident is given to the director of the facility or their designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with medications. All staff assisting with medications shall have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications. C. No medications, including over the counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order by the physician and entry into the resident's record. D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and side-effects. E. Medications prescribed for one resident shall not be used for another resident. F. The facility shall have a Medication Administration Record (MAR) documenting medications administered to residents, including over-the-counter medications. This documentation shall include: (1) Name of resident. (2) Date started. (3) Drug product name. (4) Dosage and form. (5) Strength of drug. (6) Route of administration (e.g. "by mouth"). (7) How often medication is to be taken.	A36	<b>decision maker signing the consent form provided to the facility by the department.</b>  <b>2. The facility will identify other residents having the potential to be affected by the same deficient practice by an immediate audit of all assisted living residents records.</b>  <b>3. The facility will monitor its corrective action by a monthly review and log of all assisted living residents records by nursing staff and a log listing each assisted living resident, confirming each months review, signed and maintained by the Health and Wellness Director.</b>  <b>4. The corrective action related to this deficiency will be completed by October 8, 2009.</b>	

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A36	Continued From page 5  (8) Time taken and staff initials. (9) Dates when the medication is discontinued or changed. (10) The name and initials of all staff administering medications. G. Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting. H. PRN Medications: The use of PRN medications must be closely monitored and supervised by the facility and is based on one or more of the following conditions: (1) The resident is capable of determining when the medication is needed. (2) The resident's physician has provided detailed instructions to the pharmacy regarding the administering of the medication. The physicians instruction for a PRN medication shall include: (a) Symptoms that might indicate the use of the medication. (b) Exact dosage to be used. (c) The exact amount of medication to be used in a 24 hour period. (d) Directions as to what to do if the symptoms persist. (e) Possible interactions or side-effects that might occur. (f) Manufacturer's label information for directions if deemed adequate by the physician. I. The facility must report all medication errors to the physician. J. The facility shall develop and follow a written policy for unused, outdated, or recalled medications being kept in the facility. [7-1-64, 9-15-70, 7019074, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.36 NMAC - Rn, 7 NMAC 8.2.36, 8-31-00] This REQUIREMENT is not met as evidenced	A36		

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A36	Continued From page 6  by: 7.8.2.36 B.  Based on records review and interview, the facility failed to obtain written consent by the resident, resident's guardian, treatment guardian, or surrogate decision maker in accordance with New Mexico law for assistance with medications for 10 of 10 sampled residents.  The findings are:  A. On 8/31/09 at 3:00 PM review of resident files revealed no evidence of written consent that allowed for assistance from facility staff with self-administration of medications.  B. On 9/2/09 at 3:00 PM during an interview with the Health and Wellness Director, she acknowledged the finding.	A36		
A46	7 NMAC 8.2.46 Water  7.8.2.46 WATER: A. A facility must be provided with an adequate supply of water which is of a safe and sanitary quality suitable for domestic use. Hot and cold running water under pressure must be distributed to all food preparation areas, lavatories, washrooms, and laundries. B. If the water supply is not obtained from an approved public system, the private water system must be inspected, tested, and approved by the Environmental Health Authority prior to licensure. It is the facility's responsibility to insure that subsequent periodic testing or inspection of such private water systems be made at intervals as prescribed by the Environmental Authority. C. The hot water temperature accessible to residents must be maintained at a minimum of 95	A46	<b>1. The violation will be corrected by daily testing, documentation and, if necessary, immediate adjustment of assisted hot water temperatures</b>  <b>2. The facility will identify other residents having the potential to be affected by the same deficient practice by testing, documenting and, if necessary, adjustment of hot water in all assisted living apartments.</b>  <b>3. The facility will monitor its corrective action by daily sampling of assisted living</b>	

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A46	<p>Continued From page 7</p> <p>degrees Fahrenheit and a maximum of 110 degrees Fahrenheit. Hot water in excess of 110 degrees Fahrenheit is permitted in kitchen and laundry areas, provided residents are supervised to prevent injury. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.46 NMAC - Rn, 7 NMAC 8.2.46, 8-31-00]</p> <p>This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.46 C. - Water</p> <p>Based on record review, observation and interview, the facility failed to maintain the hot water temperature accessible to residents between 95 and 110 degrees Fahrenheit.</p> <p>The findings are:</p> <p>A. On 9/3/09 during direct observation of the water temperatures of the resident accessible toilet rooms, the water temperature was observed to be:</p> <ol style="list-style-type: none"> <li>1. Private Room 223- 118.0</li> <li>2. Private Room 229 - 116.0</li> <li>3. Private Room 226 - 114.0</li> <li>4. Private Room 117 - 114.0</li> </ol> <p>B. On 9/3/09 during record review of the Preventive Maintenance Checklists for water temperatures revealed that in June and July of 2009, 90% of the water checks displayed a temperature of over 110.0. Water was not adjusted after the findings to meet the requirement.</p> <p>B. On 9/3/09 during interview with Executive Director, he acknowledged the finding.</p>	A46	<p><b>apartment water temperatures. The schedule of the testing will ensure each assisted living apartment is tested monthly. A log of the testing will be maintained and signed monthly by the director of maintenance and the executive director.</b></p> <p><b>4. The corrective action related to this deficiency will be completed by October 8, 2009.</b></p>	

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A59	Continued From page 8	A59	<ol style="list-style-type: none"> <li><b>1. The violation will be corrected by an immediate request to the Fire Marshall for an annual inspection.</b></li> <li><b>2. The facility will identify other residents having the potential to be affected by the same deficient practice by maintaining documentation of all requests to the fire marshal for annual or other inspections.</b></li> <li><b>3. The facility will monitor its corrective action by an annual computer generated reminder of the inspection due entered into the computers of the executive director and the director of maintenance.</b></li> <li><b>4. The corrective action related to this deficiency was completed on September 3, 2009.</b></li> </ol>	
A59	<p>7 NMAC 8.2.59 Fire Clearance &amp; Inspections</p> <p><b>7.8.2.59 FIRE CLEARANCE AND INSPECTIONS:</b></p> <p>A. Written documentation from the State Fire Marshall's office or Fire Prevention Authority having jurisdiction indicating a facility's compliance with applicable fire prevention codes shall be submitted to the Licensing Authority prior to issuance of a initial license.</p> <p>B. Each facility shall request from the local fire prevention authorities an annual fire inspection. If the policy of the local fire department does not provide for annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility. [7-1-64, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.59 NMAC - Rn, 7 NMAC 8.2.59, 8-31-00]</p> <p>This REQUIREMENT is not met as evidenced by: <b>7.8.2.59 B. - FIRE INSPECTIONS</b></p> <p>Based on records review and interview, the facility failed to maintain documentation of an annual fire inspection.</p> <p>The findings are:</p> <p>A. On 9/2/09 at 3:00 PM review of facility records revealed no documentation of an annual fire inspection since 2007.</p> <p>B. On 9/2/09 during an interview with the Executive Director, he acknowledged the finding.</p>	A59		

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A62	Continued From page 9	A62	<p><b>1. The violation will be corrected by increasing the monthly inspection of apartment fire extinguishers to bi-weekly .</b></p> <p><b>2. The facility will identify other residents having the potential to be affected by the same deficient practice by an immediate inspection of all fire extinguishers.</b></p> <p><b>3. The facility will monitor its corrective action by bi-weekly inspections and maintenance of a log of the inspections by the Health and Wellness Director.</b></p> <p><b>4. The corrective action related to this deficiency was completed on September 9, 2009.</b></p>	
A62	<p>7 NMAC 8.2.62 Fire Extinguishers</p> <p><b>7.8.2.62 FIRE EXTINGUISHERS:</b>  A. As approved by the State Fire Marshall or Fire Prevention Authority having jurisdiction must be located in the facility. Facilities must as a minimum have two (2) 2A10BC fire extinguishers, one (1) located in the kitchen or food preparation area, and one (1) centrally located in the facility. All fire extinguishers shall be inspected yearly and recharged as needed. All fire extinguishers must be tagged noting the date of inspection.  B. Fire extinguishers, alarm systems, automatic detection equipment, and other fire fighting equipment must be properly maintained and inspected as recommended by the manufacturer, State Fire Marshall, or Fire Authority having jurisdiction.  [7-1-64, 9-24-76, 7-11-86, 4-7-97; 7.8.2.62 NMAC - Rn, 7 NMAC 8.2.62, 8-31-00]  This REQUIREMENT is not met as evidenced by:  <b>7.8.2.62 - FIRE EXTINGUISHERS</b></p> <p>Based on observation and interview the facility failed to recharge fire extinguishers as needed for 2 of 6 sampled extinguishers.</p> <p>A. On 9/3/09 at 1:00 PM a tour of the facility revealed that 2 fire extinguishers located in resident rooms showed they needed to be recharged on the gauge provided.</p> <p>B. On 9/3/09 at 2:00 PM during an interview with the Maintenance Director, he stated that the staff check them monthly.</p>	A62		
A63	7 NMAC 8.2.63 Staff & Resident Fire & Safety Training	A63	<p><b>1. The violation will be corrected by adhering to the required fire drill schedule and procedures specified in 7NMAC 8.2.63.</b></p>	

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A63	Continued From page 10  7.8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff personnel of the facility must know the location of and be instructed in proper use of fire extinguishers and other procedures to be observed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff must be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways, and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident must upon being accepted into the facility be given an orientation tour of the facility to include, but not be limited to, the location of the exits, fire extinguishers, and telephones, and shall be instructed in action to be taken in case of fire or other emergency. D. Fire Drills: The facility must conduct at least one (1) fire drill each month: (1) Fire drills must be held at different times of the day. (2) The fire alarm system or detector system in the facility shall be used in the conduct of fire drills. (3) In the conduct of fire drills, emphasis must be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of fire drills held must be maintained on file in the facility. Such record must show date and time of the drill, number of personnel participating in the drill, any problem noted during the drill and the evacuation time in total minutes. (5) The local fire department should be	A63	<b>2. The facility has identified that all residents have the potential to be affected by the same deficient practice.</b>  <b>3. The facility will monitor its corrective action by maintaining a complete record of the monthly fire drills, signed by the executive director.</b>  <b>4. The corrective action related to this deficiency will be completed by October 8, 2008.</b>	

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NAME OF PROVIDER OR SUPPLIER  <b>PONCE DE LEON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 ALTA VISTA STREET SANTA FE, NM 87505</b>		
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A63	Continued From page 11  requested to supervise and participate in fire drills. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.63 NMAC - Rn, 7 NMAC 8.2.63, 8-31-00]  This REQUIREMENT is not met as evidenced by: 7.8.2.63 - STAFF AND RESIDENT FIRE AND SAFETY TRAINING  Based on record review and interview, the facility failed to, in the conduct of fire drills, emphasize orderly evacuation and maintain a record of the evacuation time in total minutes.  The findings are:  A. On 9/3/09 at 1:30 PM review of monthly fire drill records for 2009 revealed that residents are not evacuated to determine orderly evacuation and evacuation time in total minutes. Fire drill logs suggest that residents are rarely involved in the actual monthly fire drill.  B. On 9/3/09 at 1:30 PM during an interview with the Maintenance Director, he acknowledged that the fire drills do not include an evacuation or resident participation.	A63		
A66	7 NMAC 8.2.66 Related Regulations & Codes  7.8.2.66 RELATED REGULATIONS AND CODES: Adult residential care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96).	A66	<b>1. The violation will be corrected by an immediate review of all personnel records and an immediate submission of any documents necessary to obtain clearance on any deficient employees/records.</b>  <b>2. The facility will identify other residents having the potential to be affected by the</b>	

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A66	<p>Continued From page 12</p> <p>B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96).</p> <p>C. Adjudicatory Hearings, New Mexico Department of Health, 7 NMAC 1.2 (2-1-96). [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.66 NMAC - Rn, 7 NMAC 8.2.66, 8-31-00]</p> <p>This REQUIREMENT is not met as evidenced by: Refer to NMAC 7.1.9.8 (A)- Caregivers Criminal History Screening Requirements (Effective January 1, 2006) - All applicants to whom an offer of employment is made must consent to a nationwide and statewide screening. A Care Provider's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider to impose appropriate administrative sanctions and penalties.</p> <p>Based on record review and interview, the facility failed to have documentation that direct care staff had been cleared through the New Mexico Caregivers' Criminal History Screening Program (CCHSP) for 4 of 10 sampled employees.</p> <p>The findings are:</p> <p>A. On 9/2/09 at 11:15 am during review of employee records, it was noted that:</p> <ul style="list-style-type: none"> <li>- Staff #2 with a hire date of 10-31-07</li> <li>- Staff #4 with a hire date of 4-23-08</li> <li>- Staff #5 with a hire date of Unknown</li> <li>- Staff #10 with a hire date of 5-23-08</li> </ul> <p>did not have documentation on file of a full Caregivers Criminal History Screening (CCHSP) clearance addressed to the current facility of employment and conducted subsequent to hire within the required timeframe.</p>	A66	<p><b>same deficient practice by and immediate review of all personnel records.</b></p> <p><b>3. The facility will monitor its corrective action by a monthly sign off of new hire personnel records by the executive director.</b></p> <p><b>4. The corrective action (submission of any necessary information to the state) related to this deficiency will be completed by October 8, 2009.</b></p>	

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A66	<p>Continued From page 13</p> <p>B. On 9/2/09 at 3:30 PM during interview with the Office Manager, she acknowledged the finding.</p> <p>Refer to NMAC 7.1.9.8 (F) - Caregivers Criminal History Screening Requirements (Effective January 1, 2006) - Requirement of Timely Submission of application for clearance no later than 20 calendar days from the first day of employment</p> <p>Based on record review and interview, the facility failed to ensure timely submission to New Mexico Caregivers' Criminal History Screening Program (CCHSP) for 4 of 10 current employees.</p> <p>The findings are:</p> <p>A. On 9/2/09 at 11:15 am during review of employee records, it was noted that:</p> <ul style="list-style-type: none"> <li>- Staff #2 with a hire date of 10-31-07</li> <li>- Staff #4 with a hire date of 4-23-08</li> <li>- Staff #5 with a hire date of Unknown</li> <li>- Staff #10 with a hire date of 5-23-08</li> </ul> <p>did not have documentation on file of a full Caregivers Criminal History Screening (CCHSP) clearance addressed to the current facility of employment and conducted subsequent to hire within the required timeframe.</p> <p>B. On 9/2/09 at 3:30 PM during interview with the Office Manager, she acknowledged the finding.</p>	A66	<p><b>1. The violation will be corrected by an immediate review of all personnel records and an immediate submission of any documents necessary to obtain clearance on any deficient employees/records.</b></p> <p><b>2. The facility will identify other residents having the potential to be affected by the same deficient practice by and immediate review of all personnel records.</b></p> <p><b>3. The facility will monitor its corrective action by a monthly sign off of new hire personnel records by the executive director.</b></p> <p><b>4. The corrective action (submission of any necessary information to the state) related to this deficiency will be completed by October 8, 2009.</b></p>	

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A66	Continued From page 14  Refer to NMAC 7.1.13.10(C)(1)(a-f) Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Incident Management System Training Curriculum Requirements  Based on record review and interview, the facility failed to ensure up-to-date training on Incident Reporting, Intake, Processing and Training Requirements with the required curriculum.  The findings are:  A. On 9/2/09 at 2:30 pm during review of the facilities records, the 2009 Incident Management Training Curriculum was not available for review.  B. On 9/2/09 at 3:30 PM during an interview with Office Manager, she acknowledged the finding.  Refer to NMAC 7.1.13.10(C)(2-3) Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Requirement to train new employees within 30 days of hire.  Based on record review and interview, the facility failed to ensure required training was conducted within the time frames set in accordance with regulations in the incident reporting, intake, processing and training requirements (NMAC 7.1.13, effective February 28, 2006) for 10 of 10 sampled facility employees.	A66	<b>1. The violation will be corrected by an immediate training of all personnel; inclusion of training material and documentation into the initial orientation of all employees. Initial orientation of new employees occurs before the employee is allowed to work "on the floor".</b>  <b>2. The facility has identified that all residents have the potential to be affected by the same deficient practice.</b>	

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A66	Continued From page 15  The findings are:  A. On 9/2/09 at 10:30 AM during review of employee records, it was noted that the Incident Reporting training, required within 30 days of hire, was not among administrative paperwork for Staff #1-10.  B. On 9/2/09 at 3:30 PM during an interview with Office Manager, she acknowledged the finding.  Refer to NMAC 7.1.13.10(D) Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Requirement to maintain documentation of Incident Management Training for all employees  Based on record review and interview, the facility failed to ensure required documentation of annual training on Incident Management Reporting process for 10 of 10 sampled facility employees.  The findings are:  The findings are:  A. On 9/2/09 at 10:30 AM during review of employee records, it was noted that the Incident Reporting training, required within 30 days of hire, was not among administrative paperwork for Staff #1-10.  B. On 9/2/09 at 3:30 PM during an interview with Office Manager, she acknowledged the finding.	A66	<b>3. The facility will monitor its corrective action by a monthly sign off of new hire personnel records by the executive director and inclusion of this training in the training records of the employee.</b>  <b>4. The corrective action (submission of any necessary information to the state) related to this deficiency will be completed by October 8, 2009.</b>  <b>1. The violation will be corrected by an immediate training of all personnel; inclusion of training material and documentation into the initial orientation of all employees. Initial orientation of new employees occurs before the employee is allowed to work "on the floor".</b>  <b>2. The facility has identified that all residents have the potential to be affected by the same deficient practice.</b>  <b>3. The facility will monitor its corrective action by a monthly sign off of new hire personnel records by the executive</b>	

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A66	Continued From page 16  Refer to NMAC 7.1.13.10(E) - Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Consumer and Guardian Orientation Packet  Based on record review and interview, the facility failed to ensure that documentation of notice to residents, family members and/or guardians regarding incident reporting was made available in orientation packet for 10 of 10 sampled residents.  The findings are:  A. On 8/31/09 at 4:00 PM during review of resident files, it was noted that Resident #1-10 had no documentation of notification to family members/guardians regarding Incident Management Reporting Requirements.  B. On 8/31/09 at 4:15 PM during an interview with the Health and Wellness Director, she acknowledged the finding.	A66	<b>director and inclusion of this training in the training records of the employee.</b>  <b>4. The corrective action (submission of any necessary information to the state) related to this deficiency will be completed by October 8, 2009.</b>  <b>1. The violation will be corrected by an immediate distribution of training material to residents, family members and/or guardians, as appropriate; obtaining signatures from same and including signed documentation into the residents file. Further, the documentation will be included in the new resident orientation packets and signatures obtained when a new resident moves in to the facility.</b>  <b>2. The facility has identified that all residents have the potential to be affected by the same deficient practice.</b>  <b>3. The facility will monitor its corrective action by monitoring of resident file</b>	