

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5647	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2007
NAME OF PROVIDER OR SUPPLIER CAREFREE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111		
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A19	<p>7.8.2.19 ADMISSIONS</p> <p>7.8.2.19 ADMISSIONS: No resident shall be admitted or retained who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. EXCEPTION: Maternity Shelters may accept residents below the age of eighteen (18).</p> <p>A. ADMISSION INTERVIEW. The Director of the facility or a designee responsible for admission and retention decisions, shall meet with the resident or the resident's agent or guardian, if the resident lacks decision-making capacity, and shall provide the resident with:</p> <ol style="list-style-type: none"> (1) The facility's program narrative. (2) The facility's rules. (3) The facility's admission agreement, including costs and charges, refund provision, and contract termination policies. (4) The facility's bed hold policy. (5) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (6) A written description of the legal rights of the residents translated into another language, if necessary. (7) The facility's staffing pattern. <p>B. RESTRICTIONS ON ADMISSIONS: Adult residential care facilities shall not admit or retain individuals requiring continuous nursing care. Conditions or circumstances that usually require continuous nursing care, may include, but not limited to the following:</p> <ol style="list-style-type: none"> (1) Ventilator dependency. (2) Pressure sores where skin loss penetrates beyond the skin, and into deeper tissue or bone, which are classified as Stage III or IV. (3) Intravenous therapy or injections directly into the vein. 	A19		

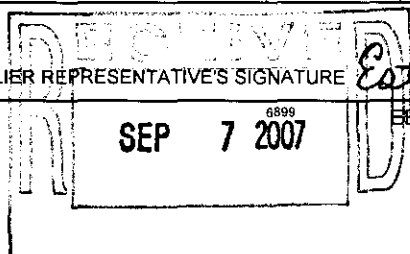
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Division of Health Improvement

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

Estephaine Pelroyanos RN TITLE _____ (X6) DATE **8/31/07**

STATE FORM




EBBN11

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A19	Continued From page 1 (4) Airborne infectious disease, in a communicable state, including tuberculosis, but excluding infections such as the common cold. (5) Any condition requiring either physical or chemical restraints. (6) Nasogastric tubes / gastric tubes. (7) Tracheostomy care. (8) Individuals presenting an imminent physical threat or danger to self or others. (9) Individuals whose physician certifies that placement is no longer appropriate. C. ADMISSION/RETENTION EXCEPTIONS: If a resident requires a greater degree of care than the facility would normally provide, or is permitted to provide, and the resident wishes to be re-admitted or to remain in the facility, and the facility wishes to re-admit or retain the resident, the facility must: (1) Convene a team, comprised of: (a) The facility director. (b) The resident. (c) The resident's agent, guardian or surrogate decision maker. (d) The resident's advocate, such as the resident's case manager, Ombudsman, or social worker. (e) If the treating physician is unable to meet with the team, then consultation and recommendations via phone is acceptable. (f) Other appropriate health care professionals. (2) The team shall jointly determine if the resident should be admitted or allowed to remain in the facility. The team must approve a individual service plan that meets the specific needs of the resident. Such team approval must be in writing, signed and dated by all team members, must be maintained in the resident's record, and must: (a) Be based upon a individual service plan which identifies the resident's specific needs	A19		

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A19	Continued From page 3 acknowledged that the facility failed to convene a team to determine whether R1, R2, R5, and R6 should be admitted and whether R4 should be retained in the facility. B. Review of R1 's resident records revealed that R1 was admitted into the facility on 8/11/06. R1 began receiving services from Odyssey Hospice prior to admission and her documented terminal illness is a fractured left ankle. Additionally, Odyssey Hospice notes indicate that R1 currently suffers from a Stage II foot ulcer. C. Review of R2 's resident records revealed that R2 was admitted into the facility on 7/20/07. R2 began receiving services from Presbyterian Hospice prior to admission and his documented terminal illness is congestive heart failure (CHF) and renal failure. D. Review of R4 's resident records revealed that R4 was admitted into the facility on 3/27/04. R4 began receiving services from Ambercare Hospice around 5/20/04 and her documented terminal illness is muscular dystrophy. E. During an interview with the Administrator/RN on 8/20/07 at 2:00 p.m., the Administrator/RN acknowledged that the facility failed to convene a team to determine whether R1 (Room 16b), R2 (Room 17a), R5 (Room 21b), and R6 (Room 24b) should be admitted and whether R4 (Room 30) should be retained in the facility.	A19	At time of R's status change, RN will notify family + convene to determine feasibility of retaining resident. B. Clarification on diagnosis RN from Odyssey noted ES. CVA on 8/27/07. RN will schedule team mtg on 9/7/07 Results will be faxed to Ruby. CFL RN will follow up 9/7/07 C. R2 is currently hosp. upon discharge from the hospice unit, team mtg will be held + document. placed in R's chart. 8/29/07 D. Team convened, all records signed by reg. members. Copy faxed to Ruby on 8/29/07. 8/28/07 E. R1 team to meet on 9/1/07 R2 upon discharge from hosp. team will meet 8/30/07 R6, R5, Team met + Record faxed to Ruby 8/29/07 When there is a change of status, resident requires hospice, team will convene + Records will be maintained by RN. <i>Stephanie Petropoulos RN</i>	Ongoing
A22	7 NMAC 8.2.22 RESIDENT RECORDS 7.8.2.22 RESIDENT RECORDS: A. RESIDENT RECORDS, CONTENTS: A record for each resident shall be maintained with specific information required. Entries in each	A22		

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A22	Continued From page 4 resident's record shall be legible, dated, and authenticated by the signature of the person making the entry. Resident records must include: (1) Admission records as set out in Section 7.8.2.21 NMAC: (2) Within five (5) days of admission: (a) An executed admission agreement. (b) A completed resident assessment form. (c) Any available, admission physical examination report by a licensed health care professional, which may include all discharge information from another facility. When admission follows within thirty (30) days discharge from an acute care hospital, the hospital history and physical report, and the hospital discharge summary may serve as an admission physical. (d) Names, addresses, relationship, and phone numbers of family members, and where appropriate, guardians, agents, and any surrogate decision makers. (3) Within thirty (30) days of admission: (a) A admission physical examination report by a licensed health care professional if an examination report was not available within five (5) days of admission. (b) Resident's name, age, recent photograph, social security number, marital status, date of birth, sex, address prior to admission, religion (optional), personal physician, dentist, social history and designated representative or other emergency contact person, language spoken and understood, legal documentation relevant to commitment and/or guardianship status, present medications, and diet required. (c) Any amendments to the admission agreement. (d) The current completed resident assessment form.	A22			

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A22	Continued From page 5 (e) A completed and current individual service plan. (f) Entries by direct care staff, appropriate health care professionals, or 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 individual service plan. (g) Entries providing a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention, and entries reflecting appropriate follow-up. The maintenance of such written record in the resident record may be by copy of an incident/accident report, if the original incident/accident report is maintained elsewhere by the facility. (h) A medication record: Medications administered by licensed personnel and/or staff assisting with medications to include: listing all currently ordered medications by name, dosage, administration times; documenting by medication name, dosage, date, and time, each medication administered, with the initials of the individual who administered or assisted with the medication; documentation of errors, omissions, and side-effects of medications; and written consent by resident or guardian for staff to assisting with medications. (i) Date, time and progress note of health services provided by any contract agency. (j) 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. (k) Transfer forms completed, signed,	A22			

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A22	Continued From page 6 and provided to accepting facility when resident is transferring to a hospital or another health care facility. (l) Documentation of disposition of the resident's personal effects and money or valuables deposited with the adult residential care facility, upon death or transfer. B. RESIDENT RECORDS, MAINTENANCE: (1) Resident records shall be maintained and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy for maintaining, and confidentiality of resident records, including the authorized release of resident records. (3) Resident records must be maintained by the facility against loss, destruction, and unauthorized use for a period of not less than three (3) years from the date of discharge. (4) There must be a policy and procedure in place for record retention in the event of facility closure. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 7.8.2.22 NMAC - Rn 7 NMAC 8.2.22, 8-31-00]  Based on records review and interview, the facility failed to maintain records of an executed admission agreement, within five days of admission, for 1 of 4 sampled residents (25%). The findings are: A. Review of R3 's resident records revealed an admission date of 12/11/04 but no evidence of an executed admission agreement.	A22		
			A. R3 records now have a Renewal agreement. <i>Estephania Petropoulos RN</i>	3/28/07

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A22	Continued From page 7 B. During an interview with the Administrator/RN on 8/20/07 at 12:30 p.m., the Administrator/RN acknowledged that there was no evidence of an executed admission agreement in R3 's resident records.	A22	<i>B. all resident records have been reviewed + contain an admission agreement. Upon admission of new clients, admission agreements will be completed - RN will monitor.</i>	<i>8/29/07</i>
A23	7 NMAC 8.2.23 FAC. REPORTS, RECS., P & PS & RULES 7.8.2.23 FACILITY REPORTS/RECORDS/POLICIES AND PROCEDURES/ AND RULES: A. REPORTS AND RECORDS: Each facility must keep the following reports, records, and policy and procedures on file at the facility and make them available for review upon request of the Licensing Authority: (1) Fire Inspection Report. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have fire inspection reports. (2) Copy of the last survey conducted by the Licensing Authority, adverse actions or appeals thereto, and complaints. (3) Copy of the latest survey from Environmental Health Authority (if applicable) regarding kitchen and food management and, if private sewage disposal, and private waste disposal. EXCEPTIONS: Adult residential care facilities with three (3) or fewer residents are not required to be inspected by Environmental Health Authority. Facilities exempted by the Environmental Health Authority having jurisdiction, are not required to have a survey on file provided the exemption letter is on file. (4) TB test results of staff or any of their family members living in the facility. (5) One (1) month of menus planned and as served.	A23		

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A23	Continued From page 8 (6) Record of fire drills: A record of all fire drills conducted at the facility. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to hold or record fire drills. (7) Written emergency plans and policies and procedures for medical emergencies, power failure, fire or natural disaster. Such plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes and refuge areas, responsibilities of personnel. (8) Licensing regulations: A copy of these regulations (Requirements for Adult Residential Care Facilities, 7.8.2 NMAC). (9) Custodial Drug Permit: A valid Custodial Drug Permit issued by the State Board of Pharmacy for those facilities licensed pursuant to these regulations. EXCEPTION: Adult residential care facilities with only one (1) resident are not required to have a custodial drug permit. (10) Vaccination of pets in the facility. (11) Staff training. (a) At orientation and on-going. (b) Appropriate to staff responsibilities. (Assistance with medications, dietary, environmental...) (c) Fire safety. (d) First aid. (e) Safe food handling practices. (f) Confidentiality of records and resident information. (g) Infection control (including universal precautions and linen handling). (h) Resident rights. (i) Providing Quality Resident care based on current resident need. (j) Reporting requirements for Abuse, Neglect or Exploitation. (12) A copy of License.	A23		

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A23	Continued From page 9 (13) Employee personnel records, including an application for employment, TB certificates, training records, and personnel actions. (14) A copy of all WAIVERS/VARIANCES granted by the Licensing Authority. (15) A copy of the floor plans as approved for licensure. B. RULES: Prior to placement in or admission to a facility, a prospective resident or his/her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to but not limited to the following: (1) The use of tobacco and alcohol. (2) The use of the telephone. (3) Operation of television, radio, and stereo. (5) Use and safekeeping of personal property. (6) Meals. (7) Use of common areas. (8) Electric blankets or appliances used by residents. C. 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, (e.g., gas leaks, injuries, transportation, medications,...). (2) Method of keeping informed when residents go outside of the facility (e.g., sign-out sheets). (3) The handling or resident's funds, if the facility provides such services. (4) Reporting of incidents, including abuse, neglect, and exploitation. (5) Handling of complaints. (6) Staff and resident fire and safety training. (7) Smoking.	A23		

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A23	Continued From page 10 (8) The facility's bed hold policy. (9) Admission agreement. (10) Admission records. (11) Resident records. (12) Program Narrative. (13) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (14) Personnel policies. (15) Identifying and safeguarding resident possessions. (16) Securing medical assistance if a resident's own physician is not available. (17) NOTE FOR MATERNITY SHELTERS ONLY: In addition to the required policy and procedure topics listed above, Maternity Shelters shall have written policies and procedures regarding infant formula, feeding and equipment, and laundering of infant linen and diapers. (18) Staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles. (19) Staff training for employees who operate motor vehicles to transport residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.23 NMAC - Rn & A 7 NMAC 8.2.23, 8-31-00] [REDACTED] by [REDACTED] Based on records review and interview, the facility failed to maintain records of ongoing (annual) staff training in fire safety, first aid, safe food handling, confidentiality of resident records, infection control, resident rights, providing quality care based on resident ' s need, and reporting requirements for abuse, neglect, and exploitation	A23		

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A23	Continued From page 11 for 4 of 4 sampled staff (100%). The findings are: A. Review of S11 's (caregiver) personnel records revealed that S11 was hired on 1/18/05. The records revealed no evidence of training in fire safety, confidentiality of records, infection control, resident 's rights, quality care based on need, and incident reporting requirements. B. Review of S12 's (caregiver) personnel records revealed that S12 was hired on 8/1/04. The records revealed no evidence of training in fire safety, first aid, confidentiality of records, infection control, resident 's rights and quality care based on resident need. C. Review of S13 's (cook) personnel records revealed that S13 was hired on 8/29/00. The records revealed no evidence of ongoing training in fire safety, first aid, safe food handling, resident 's rights, and quality care based on resident need. D. Review of S14 's (caregiver) personnel records revealed that S14 was hired on 6/28/02. The records revealed no evidence of ongoing training in fire safety, confidentiality of records, infection control, resident 's rights, quality care based on resident need, and incident reporting requirements. E. During an interview with the Administrator/RN on 8/20/07 at 12:00 p.m., the Administrator/RN acknowledged that the facility failed to maintain records of ongoing training in the above topics for S11-S14.	A23	A. S11 attended meeting held on resident rights, confidentiality, will attend First aid, infection control - 8/21/07 8/24/07 B. S12 attended staff mtg on Resident rights, confidentiality, attended mtg on First aid, infection control 8/21/07 8/24/07 C. S13 attended mtg on abuse, neglect + exploitation she will attend an annual inservice. 8/23/07 D. S14 attended staff mtg on fire safety, confidentiality, infection control, resident rights 8/21/07 8/23/07 8/24/07 E. Records will be maintained with annual training on above topics - RN will review - 8/29/07	
A26	7 NMAC 8.2.26 RESIDENT ASSESSMENT 7.8.2.26 RESIDENT ASSESSMENT:	A26		

Stephanie Petropoulos RN

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A26	<p>Continued From page 12</p> <p>A. A resident assessment to determine level of function and if the client's needs can be met by the facility. The initial assessment must be completed within five (5) days of admission and reviewed every six (6) months as part of the individual service plan.</p> <p>B. The resident assessment must establish a baseline in the resident's functional status and thereafter, identify resident changes through periodic reassessments.</p> <p>C. The resident assessment must be documented on a state approved resident assessment form and at a minimum include the following:</p> <ol style="list-style-type: none"> (1) Cognitive patterns. (2) Communication/hearing patterns. (3) Vision patterns. (4) Physical functioning and structural problems. (5) Continence. (6) Psycho social well-being. (7) Mood and behavior patterns. (8) Activity pursuit patterns. (9) Disease diagnoses. (10) Health conditions. (11) Oral/nutritional status. (12) Oral/dental status. (13) Skin conditions. (14) Medication use. (15) Special treatment and procedures. <p>D. The resident admission assessment, the physical exam report, and the observation and evaluation of staff with regards to the needs will be used to develop the individual service plan, if needed. If the resident assessment does not indicate a need for an individual service plan, then an individual service plan is not required. However, an individual service plan must be prepared for residents requiring nursing services. [4-7-97; 7.8.2.26 NMAC - Rn, 7 NMAC 8.2.26,</p>	A26			

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A26	Continued From page 13 8-31-00] [REDACTED] [REDACTED] Based on record review and interview, the facility failed to develop an initial assessment, within five days of admission, for 1 of 4 sampled residents (25%). The findings are: A. Review of R2 's resident records revealed an admission date of 7/20/07 but no evidence of an initial assessment. B. During an interview with the Administrator/RN on 8/20/07 at 1:00 p.m., the Administrator/RN acknowledged that there was no evidence of an initial assessment in R2 's resident records.	A26	A. R2's assessment + POC completed - B. All resident records have been reviewed + contain updated POC -	8/20/07 8/29/07
A27	7 NMAC 8.2.27 INDIVIDUAL SERVICE PLAN 7.8.2.27 INDIVIDUAL SERVICE PLAN: A. An individual service plan, if prompted by the resident assessment, shall be developed and implemented within fourteen (14) days of admission, and must address those areas of need as identified in the resident assessment. The individual service plan must be reviewed by a licensed nurse at least every six (6) months, and revised as needed at the time of each assessment and consistently implemented in response to the resident's needs. B. The individual service plan must include the following: (1) Description of identified needs as noted in the resident assessment. (2) Written description of what services will be provided. (3) Who will provide the services. (4) When or how often the services will	A27	A. ISP will be completed within 14 days of admission - RN will review + sign every 6 months	8/29/07

Estephania Petropoulos RN

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A27	Continued From page 14 be provided. (5) How the services will be provided. (6) Where the services will be provided. (7) Goal and outcome of the service. (8) Documentation of the facility's determination that it is able to meet the needs of the resident. [7-11-86, 1-11-90, 4-7-97; 7.8.2.27 NMAC - Rn, 7 NMAC.8.2.27, 8-31-00] [REDACTED] is not met as evidenced by: [REDACTED] Based on records review and interview, the facility failed to develop and implement an individual service plan (ISP) within fourteen days of admission and have a licensed nurse review it at least every six months for 4 of 4 sampled residents (100%). The findings are: A. Review of R1 ' s resident records revealed an admission date of 8/11/06. R1 ' s ISP was developed by the facility on 8/12/06 but has not been signed as reviewed since that date. B. Review of R2 ' s resident records revealed an admission date of 7/20/07. R2 ' s resident records revealed no evidence that an ISP had been developed by the facility. C. Review of R3 ' s resident records revealed an admission date of 12/11/04. R3 ' s ISP was developed by the facility on 12/22/04, reviewed by a licensed nurse on 6/05, but has not been signed as reviewed since that date. D. Review of R4 ' s resident records revealed an admission date of 3/27/04. R4 ' s ISP was developed by the facility on 3/04 but has not been signed as reviewed since that date.	A27	A R1's ISP has been reviewed, updated + signed by RN. B. R2's ISP developed by RN C. R3's ISP Reviewed + signed by RN D. R4's ISP reviewed + signed by RN	8/20/07 8/20/07 8/20/07 8/20/07

Esther Petropoulos RN

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A27	Continued From page 15 E. During an interview with the Administrator/RN on 8/20/07 at 12:00 p.m., the Administrator/RN acknowledged that the facility failed to develop and implement R2 's ISP within fourteen days of admission and failed to have a licensed nurse review R1, R3, and R4 's ISP 's at least every six months.	A27	E. R's ISP completed R1, R3, R4 - all ISP reviewed + dated RN will assess and review ISP. every 6 months <i>Estephanie Petropoulos RN</i>	8/20/07 8/20/07 8/20/07
A32	7 NMAC 8.2.32 HANDLING OF EMERGENCIES 7.8.2.32 HANDLING OF EMERGENCIES: A. Each resident or resident representative shall designate upon admission, a physician to be called in case of medical necessity. Each resident or representative may also designate a concerned person to be called in case of an emergency. The facility shall establish a policy to secure medical assistance if the resident's own physician is not available. In the event of an illness or an injury to the resident, an appropriately licensed health professional must be notified by the facility. B. The facility must have available, a first aid kit containing gauze, tape, adhesive, antiseptic, and bandages for emergencies. The first aid kit must be kept in a designated, easily accessible place within the facility. C. An easily accessible and functional telephone for summoning help in case of an emergency must be available in each facility. A pay telephone will not fulfill this requirement. D. A list of emergency numbers, including, but not limited to, Fire Department, Police Department, Ambulance Services, Poison Control, Licensing and Certification, Adult Protective Services, and Ombudsman must be posted near each public telephone in the facility. [7-1-64, 9-15-70, 5-26-72, 7-19-75, 9-24-76, 7-11-86, 1-1-90, 4-7-97; 8.2.32 NMAC - Rn, 7	A32		

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A32	Continued From page 16 NMAC 8.2.32, 8-31-001 _____ _____ _____ Based on observation and interview, the facility failed to post emergency numbers, including Fire, Police, Ambulance, Poison Control, Licensing & Certification, APS, and the Ombudsman near each public telephone. The findings are: A. Observation of the two public telephones in the facility on 8/20/07 at 9:20 a.m. revealed no posting of the required emergency phone numbers. B. During an interview with the Administrator/RN on 8/20/07 at 9:20 a.m., the Administrator/RN acknowledged that the required phone numbers were not posted near the public telephones.	A32	<i>A. Emergency numbers are posted at 2 public telephones.</i> <i>B. Staff will assure numbers are NOT removed.</i> <i>Estephanie Petropoulos RN</i>	<i>8/20/07</i> <i>8/20/07</i>
A34	7 NMAC 8.2.34 RESIDENT RIGHTS 7.8.2.34 RESIDENT RIGHTS: All licensed facilities shall be aware of, protect, and enhance the rights of all residents. A. Prior to admission to a facility, a resident and/or legal representative shall be given a written description of the legal rights of the residents translated into another language, if necessary, to meet the residents understanding. B. If the resident is incapable of understanding his/her legal rights, and if he/she has no legal representative, then the licensee shall also give a written copy of the resident's legal rights to one of the following persons, in this order of priority: (1) the resident's spouse; (2) any of the resident's adult children; (3) either of the resident's parents;	A34		

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A34	Continued From page 17 (4) any relative the resident has lived with for six or more months before admission; (5) a person who has been caring for, or paying benefits on behalf of the resident; (6) a placing agency; or (7) any other person, e.g., Ombudsman. C. These resident rights and the telephone number for the Ombudsman Program shall be posted in a conspicuous place in the facility: D. The facility, to protect resident rights must: (1) Treat all residents with courtesy, respect, dignity and compassion. (2) To the extent that resident required services fall within the scope of the facilities program, avoid discrimination in admission or services because of a resident's age, race, religion, physical or mental disability, or nationality. (3) Furnish residents written information about all services provided by the facility and their costs, and advance written notice of any changes. (4) Assure that residents have a safe and sanitary living environment. (5) Provide humane care. (6) Assure the resident's rights to privacy in medical care, including privacy during medical examinations, consultations and treatment; and protect the confidentiality of the resident medical records. (7) Protect and assure the resident's 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. (8) Assure the resident's right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and assure the	A34		

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A34	Continued From page 18 resident's right's to receive visits from family, friends, lawyers, ombudsmen and community organizations. (9) Prohibit the use of any and all physical and chemical restraints. (10) Assure the residents are free from physical and emotional abuse and neglect. (11) Assure that all residents are free from financial abuse and exploitation by facility staff and/or management. (12) Consistent with the resident's health, abilities and security, assure the right of the resident to freely participate in religious, social, community and other activities; and freely associate with persons in and out of the facility. (13) Permit the residents to leave the facility freely and return without unreasonable restriction. (14) Prevent unjustified room transfers or discharge from this facility. (15) Use care and management practices that foster social interaction and avoid practices that unnecessarily result in social isolation. (16) Provide services consistent with informed consent. (17) Assure that all residents may voice grievances to the facility staff, public officials, the ombudsmen or any other person, without fear of reprisal or retaliation. (18) Promptly address and resolve resident complaints. (19) Foster resident participation and understanding in the development, review and modification of the resident's plan for care and treatment. (20) Respect a resident's choice of doctor, pharmacist and other health care provider. (21) Respect a resident's medical	A34		

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A34	Continued From page 19 treatment decisions and advance directives, such as living wills and durable powers of attorney for health care. (22) Respect a resident's right to keep and use personal possessions without loss or damage. (23) Allow each resident to manage and control the resident's personal finances to the extent that the resident is able, and provide to every resident a written record of all financial arrangements and transactions involving that resident's funds. (24) Allow residents to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management. (25) Require no resident to work for the facility. (26) Consult with the incapacitated resident regarding his/her care, regardless of the involvement of a guardian or surrogate decision maker. (27) Assure the involvement in, and consent of, an incapacitated resident's guardian or surrogate decision maker in the resident's care. E. The resident's rights shall not be restricted unless the resident agrees to such a restriction, and unless this restriction is described in detail in his/her individual service plan. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.34 NMAC - Rn, 7 NMAC 8.2.34, 8-31-00] _____ by _____ _____ Based on interview, observation, and records review, the facility failed to protect resident's rights by prohibiting the use of physical restraints for 1 of 1 total resident with full bed rails (100%).	A34		


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A34	Continued From page 20 The findings are: A. During an interview with the Administrator/RN on 8/20/07 at 11:00 a.m., the Administrator/RN revealed that R7 had a bed delivered that was equipped with full bed rails. The Administrator/RN revealed that the rails on the side of the bed next to the wall were up and the opposite side was kept down. B. Observation of R7 ' s bed on 8/20/07 at 11:00 a.m., revealed that it was equipped with full bed rails; the rails on the side of the bed next to the wall were up and the opposite side was down. C. During an interview with the Administrator/RN on 8/20/07 at 11:00 a.m., the Administrator/RN revealed that R7 ' s condition did not require the use of full bed rails. The Administrator/RN acknowledged that the facility failed to prohibit the use of physical restraints (full bed rails) and indicated that she would have them removed and/or order a bed with partial rails.	A34	A R7's bed rails have been changed to 1/2 Bed rails. B, R7's bed rails are 1/2 now. C. Partial bed rails are in place. ONLY partial bed rails are permitted at CFL, all admissions will abide by this. <i>Estephanie Pothopoulos RN</i>	8/20/07 8/20/07 8/20/07 8/31/07
A35	7 NMAC 8.2.35 CUSTODIAL DRUG PERMIT 7.8.2.35 CUSTODIAL DRUG PERMIT: Any facility licensed pursuant to these regulations who supervises the administration, self-administration, or safeguards medications for residents, must have a current custodial drug permit issued by the State Board of Pharmacy. EXCEPTION: Adult residential care facilities with one (1) resident are not required to have a custodial drug permit. A. PROCUREMENT, LABELING, AND STORAGE: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as required by the individual or specified by the	A35		

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A35	Continued From page 21 individual's health care plan. The facility shall procure, label, and store medications for residents in a manner which shall be in compliance with state and federal laws. (1) All medications, including non-prescription drugs, will be stored in a locked compartment or in a locked room, as approved by the Board of Pharmacy, and the key will be in the care of the director or designee. (2) Internal medication must be kept separate from external medications. Drugs to be taken by mouth will be separated from all other dosage forms. (3) A separate locked compartment will be available in the refrigerator for those items labeled "keep in refrigerator." The refrigerator temperature will be kept between thirty-five (35) and forty-five (45) degrees Fahrenheit. A thermometer is required to be kept in the refrigerator. (4) All medications, including non-prescription medications, must be stored in separate compartments for each resident and all medications will be labeled with the residents' names. (5) A resident may be permitted to keep his/her own medication in a secure place in his/her room for self-administration if the physician's report has deemed it appropriate that the resident do so. (6) The facility may not require the resident to purchase prescriptions from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes must comply with National Fire Protection Association (NFPA) 99. B. CONSULTING PHARMACIST: The facility shall maintain records demonstrating the	A35		

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A35	<p>Continued From page 22</p> <p>consulting pharmacist provides the following:</p> <p>(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 must be reported to the Director of the facility and these irregularities must be acted upon.</p> <p>(2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation.</p> <p>(3) Consultation is 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.</p> <p>[7-1-64, 9-15-70, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.35 NMAC - Rn, 7 NMAC 8.2.35, 8-31-00]</p> <p>_____ by: _____</p> <p>Based on records review, observation, and interview the facility failed to maintain a system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. The findings are:</p> <p>A. Review of consulting pharmacist records (sign-in sheets and general check-sheets) revealed that the pharmacists reviewed the facility on 7/31/07 and reported no irregularities. However, there were no records indicating that each resident 's medications had been reviewed and reconciled.</p> <p>B. Observation of R1 's stored medication on</p>	A35	<p>A. Consulting pharmacist, Dale McKinstry will provide a record indicating all medications have been reviewed. RN will monitor future pharmacy reviews + assure records are obtained. Estephania Petrovniks RN</p>	<p>8/20/07</p> <p>8/31/07</p>

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A35	Continued From page 23 8/20/07 at 1:30 p.m. revealed a bottle of haloperidol (1 mg) and a bottle of hyoscyamine (.125 mg). Review of R1 ' s physician ' s orders and MAR revealed no evidence of physician ' s orders and no listing of the medications on R1 ' s MAR. C. Observation of R4 ' s stored medications on 8/20/07 at 1:30 p.m. revealed a bottle of Roxanol (liquid morphine), 20 mg. per ml., PRN (as needed), with 12 ml. remaining. Review of R4 ' s controlled substances log revealed that R4 was last given roxanol in 12/06 and the remaining amount was documented as 27.5 ml. D. During an interview with the Administrator/RN on 8/20/07 at 1:30 p.m., the Administrator/RN revealed that R1 ' s Odyssey Hospice nurse brought haloperidol and hyoscyamine for R1 ' s use if she experienced a decline in health but the nurse failed to deliver physician ' s orders for the drugs. The Administrator/RN explained that the drugs were not documented on R1 ' s MAR because she had not taken them. E. During an interview with the Administrator/RN on 8/20/07 at 1:30 p.m., the Administrator/RN acknowledged that the amount of roxanol present in R4 ' s bottle (12 ml.) did not coincide with the amount documented on the controlled substances log (27.5 ml.) and she was unable to provide an accurate reconciliation of the drug.	A35	B. haloperidol + hyoscyamine are part of a comfort kit medications have been returned to hospice 8/22/07 C. R4'S MARS reviewed, Oxycodone was given + not signed out on NARC sheet. Roxinol was given Feb, april, may + june this accounts for missing Roxanol. 8/29/07 D. MD orders have been obtained for R1's haloperidol + hyoscyamine 8/30/07 E. ALL narcotics must be signed out when given. RN will monitor counts + verify count is correct on a daily basis. 8/20/07 Estephaine Petropoulos RN	
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. A. Licensed health care professionals are	A36		

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A36	Continued From page 24 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. (8) Time taken and staff initials.	A36		

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A36	Continued From page 25 (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 physician's 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] 	A36		

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A36	<p>Continued From page 26</p> <p>[REDACTED]</p> <p>Based on records review and interview, the facility failed to restrict medication administration to licensed health care professionals. The findings are:</p> <p>A. Review of S11 's (unlicensed caregiver) personnel records revealed a note dated 10/29/06 written by S11 wherein she reported that she accidentally stuck herself with a used needle.</p> <p>B. During an interview with the Administrator/RN on 8/20/07 at 12:30 p.m., the Administrator/RN revealed that S11 's incident was related to R3 's injectible diabetes medications. The Administrator/RN explained that R3 usually injects her medications herself but sometimes the Administrator/RN, or a medication assistant whom she had trained, perform the injections.</p> <p>[REDACTED]</p> <p>Based on observation, records review, and interview, the facility started resident medications without an order by the physician for 2 of 4 sampled residents (50%). The findings are:</p> <p>A. Observation of R1 's stored medications on 8/20/07 at 1:00 p.m. revealed a tube of hydrocortisone. Review of R1 's August 2007 medication administration record (MAR) revealed an entry for hydrocortisone initialed by staff attesting that the medication had been given. Review of R1 's physician 's orders revealed no evidence of a physician 's order for hydrocortisone.</p> <p>B. Observation of R3 's stored medications on 8/20/07 at 1:00 p.m. revealed a bottle of ocuvite.</p>	A36	<p>A, S11 was assisted R2 on self injection of insulin 8/20/07</p> <p>B. Injections for R3 will be given by resident or R.N. only. 8/20/07</p> <p>A. The order for hydrocortisone R1 has been reviewed. it was placed in R1's Record. In the future, all OTC medications will have an M.D. order prior to administration. 8/21/07</p> <p style="text-align: right;">Estephania Petrovich RN</p>

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A36	Continued From page 27 Review of R2 ' s August 2007 MAR revealed an entry for ocuvite initialed by staff attesting that the medication had been given. Review of R3 ' s physician ' s orders revealed no evidence of a physician ' s order for ocuvite. C. During an interview with the Administrator/RN on 8/20/07 at 1:15 p.m., the Administrator/RN acknowledged that the facility started R1 ' s hydrocortisone and R3 ' s ocuvite without documented physician ' s orders. 7.0.2.301 (8,10) Based on records review and interview, the facility failed to document medications administered to residents on the medication administration record (MAR) with (a) the time taken and staff initials and (b) the name and initials of all staff administering medications for 4 of 4 sampled residents (100%). The findings are: A. Review of R1- R4 ' s August 2007 MAR ' s revealed no identifying signatures of the staff initialing the MAR ' s. B. Review of R3 ' s August 2007 MAR revealed no staff initials attesting that a medication was given during the evening shift on 8/10/07. C. During an interview with the Administrator/RN on 8/20/07 at 1:15 p.m., the Administrator/RN acknowledged that R1-R4 ' s August 2007 MAR ' s did not contain the identifying signatures of the persons initialing the documents. The Administrator/RN further acknowledged that the 8/10/07 evening shift entry on R3 ' s MAR was not initialed by staff. Therefore, it is unknown whether R3 received her prescribed medication.	A36	B. Ocuvite order for R2 was obtained. 8/22/07 C. all OTCs will not be accepted from family until we obtain an MD. order - medications will be reviewed by RN to assure MD. orders are in place. 8/30/07 A. Signature sheet is in place for MAR - initials 8/21/07 B. R3's meds had been given, evening caregivers did initial 8/20/07 C. Staff reminded to initial all meds given. Caregivers & RN will review MAR sheets to assure all meds given are initialed - 8/21/07 Estephane Pethopoulos RN 8/31/07	

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A36	Continued From page 28 Based on records review, observation, and interview, the facility failed to immediately give medication removed from the pharmacy container to 1 of 4 sampled residents (25%). The findings are: A. Review of R3 ' s resident records revealed that R3 was diagnosed with diabetes (in addition to congestive heart failure). B. Observation of the medication refrigerator on 8/20/07 at 1:45 p.m. revealed two plastic bags with R3 ' s name on them containing vials of humalog and lantus and several pre-drawn syringes of each medication. C. During an interview with the Administrator/RN on 8/20/07 at 1:45 p.m., the Administrator/RN revealed that she removed R3 ' s humalog and lantus from the vials and pre-filled the syringes. The Administrator/RN acknowledged that the facility removed the humalog and lantus from the pharmacy containers (vials) and failed to immediately give them to R3.	A36	A. R3 has diabetes - insulin dependent. B. RN will draw insulin at the time of administration. C. RN will draw insulin prior to administration on all residents requiring insulin - Estephane Pethopoulos RN	8/20/07 8/20/07
A37	7 NMAC 8.2.37 NUTRITION 7.8.2.37 NUTRITION: Each facility shall provide planned and nutritionally balanced meals in accordance with the recommended daily dietary allowance from the basic food groups to meet the nutritional needs of the age group. A. At least three (3) meals shall be served daily at regular times, or in accordance with the program narrative. (1) No more than a sixteen (16) hour span may exist between a substantial evening meal and breakfast. Snacks must be made	A37		

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A37	Continued From page 29 available between meals and in the evening and must be listed on the daily menu. Vending machines shall not be considered a source of snacks. (2) A sufficient amount of time shall be allowed for meals to enable residents to eat at a leisurely pace and to socialize. B. A copy of the current week's menu, including snacks and therapeutic diets, shall be posted where residents and families can see it. Posted menus shall be followed and any substitution must be of equivalent nutritional value and recorded on the posted menu. Menus as served must be kept for thirty (30) days and be available to the public. Identical menus shall not be used on a one (1) week cycle basis. C. Therapeutic diets and prescribed vitamin and mineral supplements shall be given and served only on the written orders of a physician. The physician's order shall become part of the resident's record and shall be updated as necessary. D. The facility shall make every reasonable attempt to accommodate the resident's food preferences, and requests by the resident or the resident's representative to observe religious or cultural dietary practices. E. Personnel handling food must be in good health, practice hygienic food-handling techniques, have good personal grooming, and be free from communicable disease transmissible via food. F. Ensure the food is prepared by methods that will conserve nutritive value, enhance flavor, appearance, and is served at the proper temperature and in a form to meet individual needs. G. All residents must be served in a dining room except for residents with a temporary illness, or documented specific personal	A37		

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A37	Continued From page 30 preference. H. If a resident consistently refuses to eat after encouragement, the resident shall be evaluated by an appropriate health professional. The resident shall be offered fluids more often during the time he/she is refusing to eat. [7-1-64, 9-15-70, 5-26-72, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.37 NMAC - Rn, 7 NMAC 8.2.37, 8-31-00] THIS REQUIREMENT IS NOT MET AS EVIDENCED BY: Based on records review and interview, the facility failed to maintain menus as served for thirty days and make them available to the public. The findings are: A. Review of facility records revealed undated menus for two weeks (fourteen days). B. During an interview with the Administrator/RN and kitchen staff on 8/20/07 at 9:10 a.m., the staff acknowledged that the facility did not maintain menus as served for thirty days.	A37		
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	A46	A. Menus have been posted 8/21/07 to cover 4 wks B. Weekly posted menus dated; a new menu will be posed each week with written dates. Stephanie Petropoulos Ad	8/21/07 8/21/07 8/31/07

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A46	<p>Continued From page 31</p> <p>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.</p> <p>C. The hot water temperature accessible to residents must be maintained at a minimum of 95 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.</p> <p>[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 _____</p> <p>Based on observation and interview, the facility failed to maintain the hot water temperature accessible to residents between 95 degrees F and 110 degrees F. The findings are:</p> <p>A. Observation and testing of the hot water in Room #23 with an indicating thermometer on 8/20/07 at 11:30 a.m. revealed that the temperature in the sink was 117.6 degrees F.</p> <p>B. During an interview with the Administrator/RN on 8/20/07 at 11:30 a.m., the Administrator/RN viewed the reading on the indicating thermometer and acknowledged that the hot water temperature accessible to residents in Room #23 was not within the allowable range.</p>	A46	<p>A. Water heater on west wing was lowered 8/20/07</p> <p>Rm 23's water temperature checked. 8/20/07</p> <p>B. CFL - maintenance person will monitor checks on water heater monthly. 8/31/07</p> <p>Estephaine Petropoulos RN</p>