STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5882	A. BUILDING: _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMINO RETIREMENT APARTMENTS	12101 LOMAS NE ALBUQUERQUE, NM 87112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation for intake NM00030019 and an On-site/Monitoring survey were completed on 08/04/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Deficiencies were cited as result of the On-site/Monitoring survey. The Complaint was substantiated 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	A 017		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Charles T Ortiz — EXECUTIVE Director — 1-16-17

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A 017	Continued From page 1 exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.17 C. Based on record review and interview the facility failed to ensure that 3 (DCS #s 1, 2 and 3) of 3 (DCS #s 1, 2 and 3) Direct Care Staff received training in the following required subjects: 1. first aid; 2. confidentiality; 3. incident reporting; 4. smoking policy. This deficient practice increases the potential to negatively impact the health, safety, and welfare of all residents by staff not knowing the proper methods of providing care and protecting residents from illness, injury or harm. The findings are: A. Record review of staff records for DCS #1 with a hire date of 03/07/16 indicated there was no documentation of training for the following: 1. first aid;	A 017	**7 NMAC 8.2.17 Staff Training** 1. **In Services for first aid , confidentiality incident reporting and smoking policy was completed by all employees on 8-19-16** 2. **Effective immediately new training book and forms are being created** 3. **The Executive Director or designee shall assure compliance with this regulation and new procedure date of completion 1-20-17**	

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A 017	Continued From page 2 2. confidentiality; 3. incident reporting; 4. smoking policy. B. Record review of staff records for DCS #2 with a hire date of 03/02/09 indicated there was no documentation of training for the following: 1. first aid; 2. confidentiality; 3. incident reporting; 4. smoking policy. C. Record review of staff records for DCS #3 with a hire date of 03/02/09 indicated there was no documentation of training for the following: 1. first aid; 2. confidentiality; 3. incident reporting; 4. smoking policy. D. On 08/03/16 at 2:20 pm, during interview, the Administrator acknowledged the training records for staff [DCS #s 1-3] are kept in an in-service book and the book has not been found. E. On 08/04/16 at 3:30 pm, during the exit interview, the Administrator acknowledged the training records for staff [DCS #1-3] kept in the in-service book had still not been found.	A 017		
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	A 021		

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A 021	Continued From page 3 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 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	A 021		

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A 021	Continued From page 4 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 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,	A 021		

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A 021	Continued From page 5 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 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: Refer to 7.8.2.21 A. (5) (a, d, e, h, l, & m) Based on record review and interview, the facility failed to ensure resident records for 3 (R #s 1 - 3) of 3 (R #s 1 - 3) residents had personal and demographic information to include the following: 1. current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; 2. recent photograph; 3. marital status; 4. address prior to admission;	A 021	**7 NMAC 8.2.21 Resident Records** 1. **Effective immediately all resident files are being reviewed and updated with all missing information** 2. **The Executive Director or Designee shall assure compliance with this regulation and new procedure** **Date of completion will be 1-20-17**	

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A 021	Continued From page 6 5. social history; 6. surrogate decision maker or other emergency contact person. This deficient practice could lead to an inability to find a resident should they disappear from the facility as the facility would not have critical information for emergency personnel to assist in finding the resident. The findings are: A. Record review of resident records for R #s 1 and 3 revealed no photograph of the residents. B. Record review of R #2's records revealed that none of the following was in the chart: 1. current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; 2. recent photograph; 3. marital status; 4. address prior to admission; 5. social history; 6. surrogate decision maker or other emergency contact person. C. On 08/04/16 at 3:30 pm, during the exit interview, the Administrator acknowledged the required documents were not in the resident records for R #s 1-3.	A 021		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by	A 025	**7 NMAC 8.2.25 Resident Evaluation** **1. Effective Immediately all resident evaluations will be completed 15 days prior to admission** **2. The Executive Director or designee shall assure compliance with this regulation and new procedure** **Date of completion 1-10-17**	

PRINTED: 01/10/2017
FORM APPROVED

Division of Health Improvement

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A 025	Continued From page 7 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 and physical examination and an evaluation report by a physician or a physician extender	A 025		

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A 025	Continued From page 8 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: Refer to 7.8.2.25 A. Based on record review and interview, the facility failed to ensure resident evaluations were completed within 15 days prior to admission for 3 (R #s 1, 2 and 3) of 3 (R #s 1, 2 and 3) residents whose evaluations were reviewed for compliance. This deficient practice could result in a delay in care and services, resulting in possible complications and the need for medical intervention. The findings are: A. Record review of R #1's chart revealed she was admitted on 01/29/16 and her admission evaluation was dated 02/04/16. B. Record review of R #2's chart revealed she was admitted on 04/04/16 and her admission evaluation was dated 04/21/16. C. Record review of R #3's chart revealed she was admitted on 12/16/15 and her admission evaluation was dated 12/20/15.	A 025		

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A 025	Continued From page 9 D. On 08/04/16 at 3:30 pm, during the exit interview, the Administrator acknowledged the 3 admission evaluations were not completed prior to admission for R #s 1 - 3.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be 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;	A 026	**7 NMAC 8.2.26 Individual Service Plan** **1. Effective immediately all Individual Service Plans (ISP's) will be completed within 10 calendar days of admission** **2. The Executive Director or designee shall assure compliance with this regulation and new procedure** **Date of completion 1-10-17**	

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A 026	Continued From page 10 (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.26 Based on record review and interview, the facility failed to ensure resident Individual Service Plans (ISPs) were completed within 10 calendar days of admission for 2 (R #2 and 3) of 3 (R #s 1, 2 and 3) residents whose ISPs were reviewed for compliance. This deficient practice could result in a delay in care and services, resulting in possible complications and the need for medical intervention. The findings are: A. Record review of R #2's chart revealed she was admitted on 04/04/16 and her ISP was dated 04/21/16. B. Record review of R #3's chart revealed she was admitted on 12/16/15 and her ISP was dated 12/30/15. C. On 08/04/16 at 3:30 pm, during the exit interview, the Administrator acknowledged the 2 ISPs were not completed within ten days of admission for R#s 2 and 3.	A 026		

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A 032	Continued From page 11	A 032		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	A 032	**7 NMAC 8.2.32 Reporting of Incidents** 1. **All Incidents reports shall be sent to DHI per regulation** 2. **Effective Immediately all incident reports will be filled out thoroughly and completely, with all follow thru documentation** 3. **Training with new incident report coordinator completed 1-16-17** 4. **The Executive director or designee shall assure compliance with this regulation and new procedure** **Date of completion 1-16-17**	

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A 032	Continued From page 12	A 032		

failed to ensure the following:
1. Submission of accurate and complete reports;
2. Reporting an incident of unusual occurrence that could cause harm to the Licensing Authority as required; and
3. Not submitting copies of investigation reports to the Licensing Authority within 5 business days after the incident.
If the facility is not reporting incidents, completing accurate reports, and completing follow-up investigation reports to the Licensing Authority then all of the residents (R #1-80) listed on the Resident Census, provided by the Administrator on 08/02/16 may be at risk of being abused, neglected, exploited, further injury, and not receiving proper care or interventions. The findings are:

A. Record review of a facility incident report received at the licensing authority on 04/25/16 revealed R #1 had a fall on 04/24/16 and revealed the following.
1. The sections provided for the following were blank:
a. Diagnosis;
b. Person responsible for individual's care, Reporting Agency, Incident Coordinator;

c. Agency address, city, Zip code, County, Phone number;
d. Initial actions taken by the agency/facility to insure health & safety;
e. Plans for further actions in response to the incident; and
f. There was nothing stating what actions were taken.
2. The only information was the resident fell in her room.
3. The facility investigation and follow up report revealed the following:

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A 032	Continued From page 13 a. It was dated as received by the licensing authority on 05/10/16, which is 16 days after the incident; b. It read, "[R #1] fractured her leg [sic] She is currently at a Rehab [sic] will return in the next couple of weeks [sic]." c. There was no documentation of an investigation. B. Record review of a facility incident report received at the licensing authority on 04/25/16 revealed R #2 was found in her room and unresponsive on 04/24/16 and revealed the following. 1. The sections provided for the following were blank: a. Diagnosis; b. Name of Consumer's Doctor and phone number c. Person responsible for Individual's care, Reporting Agency, Incident Coordinator; d. Agency address, city, Zip code, County, Phone number; and e. Plans for further actions in response to the incident. 2. The only information was the resident was unresponsive and 911 was called. 3. The facility investigation and follow up report revealed the following: a. It was dated as received by the licensing authority on 05/10/16, which is 15 days after the incident; b. It read, "[R #2] returned back to [facility name] [sic] is doing well [sic]" c. There was no documentation of an investigation. C. Record review of a facility incident report received at the licensing authority on 04/29/16	A 032		

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A 032	Continued From page 14 revealed R #3 had a blood oxygen saturation of 81 (low) requiring paramedics to be called on 04/28/16 and revealed the following. 1. The sections provided for the following were blank: a. Diagnosis; b. Person responsible for Individual's care, Reporting Agency, Incident Coordinator; c. Agency address, city, Zip code, County, Phone number; d. Initial actions taken by the agency/facility to insure health & safety; e. Plans for further actions in response to the incident; and f. There was nothing stating what actions were taken. 2. The only information given was R #3 had an oxygen level of 81 and paramedics were called. 3. The facility investigation and follow up report revealed the following: a. It was dated as received by the licensing authority on 05/10/16, which is 12 days after the incident; b. It read, "[R #3] has returned back to [facility name]. We will keep an eye on him." c. There was no documentation of an investigation. D. On 08/02/16 at 11:05 am, in an interview with DCS #6 as he exited room #206, he was asked why there were room furnishings, walkers, wheelchairs, a refrigerator, and boxes in the hallway/corridor on the second floor. He stated that the rooms were being repaired due to water damage from a resident in room #306 above on the third floor setting his bed on fire and the sprinkler system spraying the fire.	A 032		

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A 032	Continued From page 15 E. Record review of a staff note signed by DCS #6 and dated 07/04/16 stated, at between 9:25 am and 9:40 am, the fire alarm sounded. DCS #6 went to the fire alarm control panel and it was showing water flow. The fire was located in apartment #306. The Independent Living Resident in apartment #306 was found sitting in his living room, the sprinkler was activated in the bedroom, and there was smoke in the room. The room smelt like burnt plastic. DCS #6 evacuated the Independent Living Resident out of apartment #306. Fire Department arrived and the building was evacuated of all residents (Assisted Living and Independent Living residents). Fire Department told DCS #6 they found lighter fluid and matches in the bed of apartment #306 where the fire started. F. On 08/02/16 at 11:18 am, in an interview with the Administrator, when asked about the fire, he confirmed an Independent Living Resident on the third floor in room #306 set his bed on fire and the Automatic Fire Protection (Sprinkler) system put out the fire. When the Administrator was asked if the facility reported the incident to the Licensing Authority, he confirmed they did not.	A 032		
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	A 034	**7 NMAC 8.2.34 Custodial Drug Permits** **1. All medications shall be stored in compliance with this regulation** **2. Medications are being stored in separate compartments for each resident** **Date of completion 8-19-16** **3. Oxygen Cylinders will be stored in a safe manner in a safe ventilated storage area** **Date of completion 2-6-17** **4. All rooms with oxygen in use will have oxygen in use signs on doors of rooms to signify oxygen** **5. The Executive Director or designee shall assure compliance with the regulation and new procedure** **Date of completion 2-6-17**	

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A 034	Continued From page 16 facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (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	A 034		

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A 034	Continued From page 17 through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall 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	A 034		

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A 034	Continued From page 18 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: Refer to 7.8.2.34 A. (4 & 7) NFPA 99/1999 4-3.5.2.2 Storage of Cylinders and Containers Level I a) Facility authorities, in consultation with medical staff and other trained personnel, shall provide and enforce regulations for the storage and handling of cylinders and containers of oxygen in storage rooms of approved construction, and for the safe handling of these agents in anesthizing locations. In storage locations, cylinders shall be properly secured in racks or adequately fastened in the upright position. b) Non Flammable Gases 1. Storage shall be planned so that cylinders can be used in the order in which they are received. 2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. 3. Cylinders stored in the open shall be protected against extremes of weather and from the ground beneath to prevent rusting. During winter, cylinders stored in the open shall	A 034		

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A 034	Continued From page 19	A 034		

be protected against accumulations of ice or snow. In summer, cylinders stored in the open shall be screened against continuous exposure to direct rays of the sun in those locations where extreme temperatures prevail.

Based on observation and interview the facility failed to protect the health and safety of 5 (R #s 4-8) of 5 (R #s 4-8) residents by not:
1. storing medications in separate compartments for each resident (R#s 4 - 7) that are diabetic; and
2. storing oxygen cylinders in a safe manner or in a safe ventilated storage area for (R #8). 3. having oxygen in use signs on the doors of rooms to signify oxygen.

This deficient practice could lead to a resident receiving insulin that is prescribed for another resident and in the event of a fire or an oxygen cylinder being knocked over, oxygen cylinders may act like a missile with the potential to harm all residents and all occupants of the building. The findings are:

A. On 08/03/16 at 4:10 pm, during a tour of the facility the medication refrigerator was observed to have insulin stored together and and not in separate compartments with the residents names for residents R #4 - 7.

B. On 08/03/16 at 4:10 pm, in an interview with DCS #4 she confirmed the medication refrigerator had insulin stored together and and not in separate compartments with the residents names for residents R #4 - 7.

C. On 08/04/16 at 10:00 am, during a tour of the facility with the Administrator, the following was observed in the room for R #8:
1. Five M-15 oxygen cylinders were laying

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A 034	Continued From page 20 down not on a rack; 2. One M-24 oxygen cylinder standing; not on a rack or secured; and 3. There was no sign on the door of the room to signify oxygen was in use. D. On 08/04/16 at 10:00 am, in an interview, the Administrator confirmed the following in the room for Resident R #8: 1. Five M-15 oxygen cylinders were laying down not on a rack; 2. One M-24 oxygen cylinder not in a rack; 3. The facility does not have a specific storage area for the oxygen cylinders that are not in use; and 4. There was no sign on the door of the room to signify oxygen was in use.	A 034		
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	A 036	**7 NMAC 8.2.36 Nutrition** **1. Effective Immediately the cooking exhaust system will be cleaned quarterly (every 3 months)** **2. The Executive Director of designee shall assure compliance with the regulation and new procedure** **Date of completion 1-20-17**	

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A 036	Continued From page 21 than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (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	A 036		

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A 036	Continued From page 22 following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall 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	A 036		

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A 036	Continued From page 23 the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a 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	A 036		

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A 036	Continued From page 24 fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water 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	A 036		

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A 036	Continued From page 25 forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.36 F. Collateral requirements Refer to National Fire and Protection Agency (NFPA) 96, " Standard for Ventilation Control and Fire Protection of Commercial Cooking Operation The fire protection system requires annual and semi-annual inspections.	A 036		

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A 036	Continued From page 26 The cooking exhaust system requires quarterly cleaning. This includes from the origin (filters and hood) the run (Duct from hood to exhaust) and the terminus (Exhaust fan). This shall be done by an authorized contractor who places a sticker on the end of the hood with the company name, date of cleaning and next scheduled date. The facility can do this themselves but, they have to clean not only the filters but the entire system from the origin, run and terminus and they SHALL document this, keeping records to be made available to the inspector. Based on record review, observation, and interview the facility failed to protect the health and safety of the facility's 80 (R #1 through 80) residents as identified by the resident census list provided by the Administrator on 08/02/16 by not having the cooking exhaust system cleaned quarterly (every 3 months). This deficient practice could lead to grease fire in the cooking exhaust system putting all residents and occupants of the building in danger. The findings are: A. On 08/03/16 at 6:35 am, during a tour of the facility there was a sticker on the cooking exhaust system signifying it had last been cleaned in October, 2015 and was due in 180 days (6 months). C. On 08/03/16 at 9:00 am, during an interview with the Administrator, he acknowledged the cooking exhaust system was cleaned only every 6 months and was unaware that had to be completed quarterly.	A 036		
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds	A 042	**7 NMAC 8.2.42 Maintenance of Building and Grounds** 1. **Effective immediately all rooms shall have functioning smoke detectors** 2. **Effective immediately smoke detectors have been installed in the beauty salon and in the TV room** 3. **The Executive Director or designee shall assure compliance with this regulation and new procedure** **Date of completion 8-6-16**	

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	5882	A. BUILDING: _____ B. WING _____	C 08/04/2016

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A 042	Continued From page 27 MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to protect the health and safety of the facility's 80 (R #s 1-80) residents identified on the resident census list provided by the Administrator on 08/02/16 by not maintaining smoke detectors in Assisted Living Resident's apartments. This deficient practice could lead to a resident being overcome by smoke and flame in the event of a fire in the apartment. The findings are: A. On 08/04/16 at 10:00 am, during tour of the facility, Assisted Living Resident room #s 205, 208, 211, 223, 226, 227, 232 and 335 had smoke detectors that did not function. The beauty salon and TV room had no smoke detectors. B. On 08/04/16 at 10:00 am, during tour of the facility with the Administrator, he acknowledged the Assisted Living Resident room #s 205, 208, 211, 223, 226, 227, 232 and 335 had smoke	A 042		

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A 042	Continued From page 28 detectors that did not function and the beauty salon and TV room had no smoke detectors.	A 042		
A 052	7 NMAC 8.2.52 Corridors CORRIDORS: A. Corridors in an existing building shall have a minimum width of thirty-six (36) inches. Corridors in newly constructed facilities shall have a minimum width of forty-four (44) inches. B. Corridors shall have a clear ceiling height of not less than seven (7) feet measured to the lowest projection from the ceiling. C. Corridors shall be maintained clear and free of obstructions at all times. D. The floors of corridors and hallways shall be waterproof, greaseproof, smooth, slip-resistant and durable. [7.8.2.52 NMAC - Rp, 7.8.2.53 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.52 C. Based on observation and interview the facility failed to ensure the health and safety of the facility's 80 (R #s 1-80) residents identified on the resident census list provided by the Administrator on 08/02/16, by having wheel chairs, a refrigerator, boxes, and divider blinds obstructing the paths to the two approved emergency exits from the second floor of the building. This deficient practice could impede the evacuation in the event of an emergency for residents and all occupants of the building. The findings are: A. On 08/02/16 at 11:00 am, during a tour of the	A 052	**7 NMAC 8.2.52 Corridors** **1. Effective immediately all corridors shall be maintained clear and free of obstructions at all times** **2. The Executive Director or designee shall assure compliance with this regulation and new procedure** **Date of completion 8-6-16**	

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A 052	Continued From page 29 facility, it was observed the facility's second floor hallway/corridor had 3 manual wheelchairs, one motorized wheelchair, 2 walkers, a refrigerator, boxes, and divider blinds obstructing the corridor for evacuation to the approved Exits. B. On 08/02/16 at 11:10 am, during an interview with DCS #5, he confirmed the facility's second floor hallway/corridor had 3 manual wheelchairs, one motorized wheelchair, 2 walkers, a refrigerator, boxes, and divider blinds obstructing the corridor for evacuation to the approved Exits.	A 052		
A 062	7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Facilities with nine (9) or more residents shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. [7.8.2.62 NMAC - Rp, 7.8.2.61 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 62 Refer to NFPA 13R 2-5.1.7.3 Sprinklers shall be positioned so that the response time and discharge are not unduly affected by obstructions such as ceiling slope, beams, or light fixtures. Based on observation and interview the facility failed to ensure the health and safety of the	A 062	**7 NMAC 8.2.62 Automatic Fire Protection (sprinkler) System** **1. Automatic fire protection sprinklers will remain unobstructed** **2. Light fixtures will be moved and items on shelves will be moved so sprinklers will be unobstructed** **3. The Executive Director or designee shall assure compliance with this regulation and new procedure** **Date of completion 2-6-17**	

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A 062	Continued From page 30 facility's 80 (R #s 1-80) residents identified on the resident census list provided by the Administrator on 08/02/16, by not ensuring automatic fire protection sprinklers were unobstructed. This deficient practice could lead to the sprinkler(s) being unable to extinguish a fire in that area. The findings are: A. On 08/04/16 at 10:00 am, during tour of the facility, Assisted Living Resident rooms #219 and #208 had light fixtures obstructing the automatic fire protection sprinkler head. The third floor storage area had items on shelves that blocked the automatic fire protection sprinkler head. B. On 08/04/16 at 10:00 am, during tour of the facility with the Administrator, he acknowledged Assisted Living Resident rooms #219 and #208 had light fixtures obstructing the automatic fire protection sprinkler head and the third floor storage area had items on shelves that blocked the automatic fire protection sprinkler head.	A 062		
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.	A 070	**7 NMAC 8.20.70 Incorporated and Related Rules and Codes** **1. All incident reports shall be sent to DHI per regulation** **2. Effective immediately all incident reports will filled out thoroughly and completely, with all follow thru documentations** **3. Training with new incident report coordinator completed 1-16-17** **4. Executive Director or designee shall assure compliance with regulation and new procedure** **Date of completion 1-16-17**	

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A 070	Continued From page 31 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: 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W, 8 A. (3), 8 B. (2), & 10 C. 7 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. 8 A. (3) All licensed health care facilities shall ensure that the reporter with direct knowledge of an incident has immediate access to the bureau incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. 8 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	A 070		

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A 070	Continued From page 32 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. 10 C. All licensed health care facilities shall conduct a complete investigation and report the actions taken and conclusions reached by the facility within five (5) days of discovery of the incident. Based on record review and interview, the facility failed to ensure the following: 1. Submission of accurate and complete reports; 2. Reporting an incident of unusual occurrence that could cause harm to the Licensing Authority as required; and 3. Not submitting copies of investigation reports to the Licensing Authority within 5 business days after the incident. If the facility is not reporting incidents, completing accurate reports, and completing follow-up investigation reports to the Licensing Authority then all of the residents (R #1-80) listed on the Resident Census, provided by the Administrator on 08/02/16 may be at risk of being abused, neglected, exploited, further injury, and not receiving proper care or interventions. The findings are:	A 070		

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A 070	Continued From page 33 A. Record review of a facility incident report received at the licensing authority on 04/25/16 revealed R #1 had a fall on 04/24/16 and revealed the following. 1. The sections provided for the following were blank: a. Diagnosis; b. Person responsible for Individual's care, Reporting Agency, Incident Coordinator; c. Agency address, city, Zip code, County, Phone number; d. Initial actions taken by the agency/facility to insure health & safety; e. Plans for further actions in response to the incident; and f. There was nothing stating what actions were taken. 2. The only information was the resident fell in her room. 3. The facility investigation and follow up report revealed the following: a. It was dated as received by the licensing authority on 05/10/16, which is 16 days after the incident; b. It read, "[R #1] fractured her leg [sic] She is currently at a Rehab [sic] will return in the next couple of weeks [sic]." c. There was no documentation of an investigation. B. Record review of a facility incident report received at the licensing authority on 04/25/16 revealed R #2 was found in her room and unresponsive on 04/24/16 and revealed the following. 1. The sections provided for the following were blank: a. Diagnosis;	A 070		

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A 070	Continued From page 34 b. Name of Consumer's Doctor and phone number c. Person responsible for Individual's care, Reporting Agency, Incident Coordinator; d. Agency address, city, Zip code, County, Phone number; and e. Plans for further actions in response to the incident. 2. The only information was the resident was unresponsive and 911 was called. 3. The facility investigation and follow up report revealed the following: a. It was dated as received by the licensing authority on 05/10/16, which is 15 days after the incident; b. It read, "[R #2] returned back to [facility name] [sic] is doing well [sic]" c. There was no documentation of an investigation. C. Record review of a facility incident report received at the licensing authority on 04/29/16 revealed R #3 had a blood oxygen saturation of 81 (low) requiring paramedics to be called on 04/28/16 and revealed the following. 1. The sections provided for the following were blank: a. Diagnosis; b. Person responsible for Individual's care, Reporting Agency, Incident Coordinator; c. Agency address, city, Zip code, County, Phone number; d. Initial actions taken by the agency/facility to insure health & safety; e. Plans for further actions in response to the incident; and f. There was nothing stating what actions were taken.	A 070		

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A 070	Continued From page 35 2. The only information given was R #3 had an oxygen level of 81 and paramedics were called. 3. The facility investigation and follow up report revealed the following: a. It was dated as received by the licensing authority on 05/10/16, which is 12 days after the incident; b. It read, "[R #3] has returned back to [facility name]. We will keep an eye on him." c. There was no documentation of an investigation. D. On 08/02/16 at 11:05 am, in an interview with DCS #6 as he exited room #206, he was asked why there were room furnishings, walkers, wheelchairs, a refrigerator, and boxes in the hallway/corridor on the second floor. He stated that the rooms were being repaired due to water damage from a resident in room #306 above on the third floor setting his bed on fire and the sprinkler system spraying the fire. E. Record review of a staff note signed by DCS #6 and dated 07/04/16 stated, at between 9:25 am and 9:40 am, the fire alarm sounded. DCS #6 went to the fire alarm control panel and it was showing water flow. The fire was located in apartment #306. The Independent Living Resident in apartment #306 was found sitting in his living room, the sprinkler was activated in the bedroom, and there was smoke in the room. The room smelt like burnt plastic. DCS #6 evacuated the Independent Living Resident out of apartment #306. Fire Department arrived and the building was evacuated of all residents (Assisted Living and Independent Living residents). Fire Department told DCS #6 they found lighter fluid and matches in the bed of apartment #306 where the fire started.	A 070		

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A 070	Continued From page 36 F. On 08/02/16 at 11:18 am, in an interview with the Administrator, when asked about the fire, he confirmed an Independent Living Resident on the third floor in room #306 set his bed on fire and the Automatic Fire Protection (Sprinkler) system put out the fire. When the Administrator was asked if the facility reported the incident to the Licensing Authority, he confirmed they did not.	A 070		