Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 Complaint investigations for intakes NM00029979, NM00030053 and an On-site/Monitoring survey were completed on 07/27/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Deficiencies were cited as result of the On-site/Monitoring survey. Complaint NM00029979 was unsubstantiated with no deficiencies cited as a result of the investigation. Complaint NM00030053 was substantiated with deficiencies cited as a result of the investigation.	A 000		
A 008	7 NMAC 8.2.8 General Licensing Requirements GENERAL LICENSING REQUIREMENTS: A. Licensure is required. No person or entity shall establish, maintain or operate an assisted living facility without first obtaining a license. B. Application for licensure. An initial or renewal application shall be made on the forms prescribed by and available from the licensing authority. The issuance of an application form is not a guarantee that the completed application will be accepted, or that the department will issue a license. Information provided by the facility and used by the licensing authority for the licensing process shall be accurate and truthful. The licensing authority will not issue a new license if the applicant has had a health facility license revoked or renewal denied or has surrendered a license under threat of revocation or denial of renewal. The licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of applicable rules found to be class A or class B deficiencies as defined in Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC or has been	A 008		

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 008	Continued From page 1 non-compliant with plans of correction. The licensing authority will not issue a license until the applicant has supplied all of the information that is required by this rule. Any facility that fails to participate in good faith by falsifying information presented in the licensing process shall be denied licensure by the department. The following information shall be submitted to the licensing authority for approval: (1) a letter of intent that includes the proposed physical address, the primary population of the facility and a summary of the proposed services; after the letter of intent has been received, an application packet including; the application form, fee schedule and the licensing rule will be issued to the applicant by the licensing authority; (2) the completed and notarized application and the appropriate non-refundable fee(s); (3) a program narrative identifying and detailing the geographic service area, the primary population including any special needs requirements, along with a full description of the services that the applicant proposes to provide including: (a) a description of the characteristics of the proposed population of the facility; (b) a description of the services and care that will be provided to the residents; (c) a description of the anticipated professional services to be offered to the residents; and (d) a description of the facility ' s relationship to other services and related programs in the service area and how the applicant will collaborate with them to achieve a system of care for the residents. (4) policies and procedures annotated to this rule; (5) evidence to establish that the applicant has sufficient financial assets to permit operation of the facility for a period of six (6) months; the	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER

MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 008	Continued From page 2 evidence shall include a credit report from one of the three recognized credit bureaus with a minimum credit score of six-hundred fifty (650) or above; (6) copies of organizational documents to include the following list of items: (a) the names of all persons or business entities that have at least five percent (5%) ownership interest in the facility, whether direct or indirect and whether in profits, land or building; this includes the owners of any business entity which owns all or part of the land or building; (b) the identities of all creditors that hold a security interest in the premises, whether land or building; (c) any changes in ownership or management shall be reported to the department within thirty (30) days; (7) building plans as required at 7.8.2.41 NMAC of this rule; (8) fire authority approval as required at 7.8.2.60 NMAC of this rule; (9) a letter of approval or exemption from the local health authority having jurisdiction for the food service and the kitchen facility; (10) a copy of liquid waste disposal and treatment system permit from local health authority having jurisdiction; (11) approval from local zoning authority; (12) building approval (certificate of occupancy); and (13) any other information that the applicant wishes to provide or that the licensing authority may request. C. Application for amended license. A licensee shall submit an application for an amended license and the required non-refundable fee to the licensing authority prior to a change with the facility. An amended license is required for a	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 008	Continued From page 3 change of: location, administrator, facility name, capacity or any modification or addition to the building. (1) An application for a change of the facility administrator or change of the administrator ' s name shall be submitted to the licensing authority within ten (10) business days of the change. (2) An application for increase in capacity shall be accompanied by a building plan pursuant to 7.8.2.41 NMAC of this rule. A facility shall not increase census until the licensing authority has reviewed and approved the increase and has issued a new license that reflects the approved increase in capacity. D. Application for license renewal. Each facility shall apply for a renewal of the annual license within thirty (30) business days prior to the license expiration date by submitting the following items: (1) an application and the required fee; (2) an updated program narrative, if the facility has changed the program or the focus of services; (3) the annual fire inspection report; and (4) the licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of this rule or has been noncompliant with plans of correction or payment of civil monetary penalties. E. License. Any person or entity that establishes, maintains or operates an assisted living facility shall obtain a license as required in this rule before accepting residents for care or providing services. (1) Each facility that provides care or treatment shall obtain a separate license. The license is non-transferable and is only valid for the facility to which it is originally issued and for the owner or operator to whom it is issued. It shall not be sold, reassigned or transferred.	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 008	Continued From page 4 (2) The maximum capacity specified on the license shall not be exceeded. (3) If the facility is closed and the residents are removed from the facility, the license shall be returned to the licensing authority. Written notification shall be issued to all residents or the residents ' surrogate decision maker and the licensing authority at least thirty (30) calendar days prior to the closure. F. Temporary license. (1) A temporary license may be issued to a new facility before residents are admitted provided that the facility has met all of the life safety code requirements as stated in this rule and policies and procedures for the facility have been reviewed and approved. (2) Upon receipt of a temporary license, the facility may begin to admit up to three (3) residents. (3) After the facility has admitted up to three (3) residents, the facility operator or owner shall request an initial health survey from the licensing authority. (4) Following a determination of compliance with this rule by the licensing authority, an annual license will be issued. The renewal date of the annual license is based on the initial date of the first temporary license. (5) The licensing authority has the right to determine compliance or noncompliance. (6) A temporary license shall cover a period of time, not to exceed one hundred twenty (120) calendar days. (7) No more than two (2) consecutive temporary licenses shall be issued. If a second temporary license is issued, an additional non-refundable fee is required. If all requirements are not met within the two hundred forty (240) day time frame, the applicant shall repeat the application process.	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 008	Continued From page 5 G. Annual license. An annual license is issued for one (1) year for a facility that has met all the requirements of this rule. H. Display of license. The facility shall display the license in a conspicuous public place that is visible to residents, staff and visitors. I. Unlicensed facilities. Any person or entity that opens or maintains an assisted living facility without a license is subject to the imposition of civil monetary penalties by the licensing authority. Failure to comply with the licensure requirements of this rule within ten (10) days of notice by the licensing authority may result in the following penalties pursuant to Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC. (1) A civil monetary penalty not to exceed five-thousand dollars ($5,000) per day. (2) A base civil monetary penalty, plus a per-day civil monetary penalty, plus the doubling of penalties as applicable, that continues until the facility is in compliance with the licensing requirements in this rule. (3) A cease and desist order to discontinue operation of a facility that is operating without a license. (4) Additional criminal penalties may apply and shall be imposed as necessary. [7.8.2.8 NMAC - Rp, 7.8.2.8 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.8 D. Based on record review and interview the facility failed to apply for annual license renewal, thirty (30) days prior to the current license's expiration date. This deficient practice has the potential to affect all 15 (R #s 1-15) residents if the facility	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 008	Continued From page 6 does not receive a current renewed license before the expiration of the current license and operates as an unlicensed facility. The findings are: A. Record review of the facility's current license revealed it expires on 07/31/16 and review of the application for annual license renewal revealed it was not signed by the Administrator until 07/21/16. B. On 07/25/16 at 2:50 pm, in an interview with the Administrator, she confirmed the application for annual license renewal was not sent to the Licensing Authority until 07/22/16.	A 008		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 016	Continued From page 7 an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC. B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 016	Continued From page 8 facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.16 B. (3 & 6) Based on record review and interview, the facility failed to ensure that 10 (DCS #s 1, 2, 4, 5, 6, 7, 8, 9, 11 and 12) of 17 (DCS #s 1-17) Direct Care Staff (DCS) met the requirements for the following: 1. Employee Abuse Registry (EAR) inquiry prior to date of hire for DCS #s 1, 2, 4, 5, 6, 7, 9, 11 and 12 records reviewed; 2. Caregiver Criminal History Screening (CCHSP) within 20 days of the date of hire for DCS #s 4, 5, 7, 8 and 11 records reviewed for CCHSP. This deficient practice has the potential to affect all 15 (R #s 1-15) residents as identified on the resident census list provided by DCS #4 on 07/20/16 by allowing a person who has been convicted of a felony or who has been placed on the EAR for Abuse, Neglect, and/or Exploitation to have access to all residents. The findings are: A. Record review findings related to Employee Abuse Registry (EAR) inquiry: 1. DCS #1's staff records revealed a date of hire as 10/20/15 and inquiry to the EAR was not completed until 11/17/15. 2. DCS #2's staff records revealed a date of	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 016	Continued From page 9 hire as 10/13/15 and inquiry to the EAR was not completed until 01/21/16. 3. DCS #4's staff records revealed a date of hire as 04/11/16 and inquiry to the EAR was not completed until 05/03/16. 4. DCS #5's staff records revealed a date of hire as 06/22/16 and inquiry to the EAR was not completed until 07/06/16. 5. DCS #6's staff records revealed a date of hire as 05/09/16 and inquiry to the EAR was not completed until 06/23/16. 6. DCS #7's staff records revealed a date of hire as 02/19/14 and inquiry to the EAR was not completed. 7. DCS #9's staff records revealed a date of hire as 04/25/16 and inquiry to the EAR was not completed until 07/06/16. 8. DCS #11's staff records revealed a date of hire as 03/07/16 and inquiry to the EAR was not completed until 06/20/16. 9. DCS #12's staff records revealed a date of hire as 06/20/16 and inquiry to the EAR was not completed until 06/24/16. B. Record review findings related to Caregiver Criminal History Screening (CCHSP): 1. DCS #4's date of hire was 04/11/16, however, the application and fingerprinting were not sent to CCHSP until 05/24/16. 2. DCS #5's date of hire was 06/22/16, however, the fingerprinting was not completed for CCHSP until 07/18/16. 3. DCS #7's date of hire was 02/19/14, however, there were no application, fingerprinting, or clearance letter for CCHSP in the records. 4. DCS #8's date of hire was 07/07/16, however, there were no application, fingerprinting, or clearance letter for CCHSP in the records. 5. DCS #11's date of hire was 03/07/16,	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 016	Continued From page 10 however, the fingerprinting was not completed for CCHSP until 07/15/16. C. On 07/21/16 at 10:00 am, in an interview with DCS #4, she acknowledged some of the facility staff records did not have EAR or CCHSP records and some were done later than the required time limits.	A 016		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors;	A 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 017	Continued From page 11 (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 A. B & C. Based on record review and interview the facility failed to have documentation ensuring that 4 (DCS #s 1, 2, 3 and 4) of 17 (DCS #s 1-17) Direct care staff received training in the following required subjects: 1. Orientation/Training with 16 hours supervised prior to unsupervised care of residents; 2. 12 hours of annual training in the subjects listed below; 3. fire safety and evacuation; 4. first aid; 5. safe food handling: 6. confidentiality; 7. infection control; 8. resident rights; 9. incident reporting; 10. quality care; 11. emergency procedures; and 12. Individual Service Plan (ISP) implementation; This deficient practice increases the potential to negatively impact the health, safety, and welfare	A 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 017	Continued From page 12 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 revealed a hire date of 10/20/15 and there was no documentation of training for the following: 1. Orientation/Training with 16 hours supervised prior to unsupervised care of residents. 2. fire safety and evacuation; 3. first aid; 4. safe food handling: 5. infection control; 6. resident rights; 7. incident reporting; 8. emergency procedures; B. Record review of staff records for DCS #2 revealed a hire date of 03/07/16 and there was no documentation of training for the following: 1. Orientation/Training with 16 hours supervised prior to unsupervised care of residents; 2. fire safety and evacuation; 3. first aid; 4. safe food handling: 5. confidentiality; 6. infection control; 7. resident rights; 8. incident reporting; 9. quality care; 10. emergency procedures; and 11. Individual Service Plan (ISP) implementation. C. Record review of staff records for DCS #3 with a hire date of 06/12/14 and there was no documentation of training for the following: 1. Orientation/Training with 16 hours	A 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 017	Continued From page 13 supervised prior to unsupervised care of residents; 2. 12 hours of annual training. 3. fire safety and evacuation; 4. infection control; 5. resident rights; 6. incident reporting; and 7. emergency procedures. E. Record review of staff records for DCS #4 revealed a hire date of 10/10/10 and there was no documentation of training for the following: 1. 12 hours of annual training; 2. fire safety and evacuation; 3. infection control; 4. resident rights; and 5. emergency procedures; F. On 07/27/16 at 9:30 am, during interview, DCS #15 acknowledged there was no further documentation of training for DCS #s 1, 2, 3 and 4.	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 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	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 021	Continued From page 14 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 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;	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 021	Continued From page 15 (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, 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	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 021	Continued From page 16 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. (4) Based on record review and interview the facility failed to protect the health and safety of 1 (R #3) of 3 (R #s 1 - 3) residents by not ensuring resident charts reviewed had a physical examination report from a primary care physician, a nurse practitioner or a physician's assistant. This deficient practice could lead to the facility Direct Care Staff to not understand the diagnoses of the resident and lead to improper care being provided for the resident. The findings are: A. Record review of the chart for R #3 revealed the resident had resided at the facility since 02/20/14 and there was no completed physical examination on file. B. On 07/27/16 at 3:00 pm, during an interview the Administrator confirmed there was no	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 021	Continued From page 17 completed physical examination report in the chart for R #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 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;	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 025	Continued From page 18 (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 within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 B & C. (16) Based on record review and interview the facility failed to ensure that 1 (R # 3) of 3 (R #s 1, 2 & 3) residents whose evaluations were reviewed for timeliness and accuracy had been reviewed every 6 months and had special medical services documented that are provided by an outside agency. This deficient practice has the potential for the residents to not receive the appropriate care and assistance they need as changes in	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 025	Continued From page 19 their health status occurs due to the evaluations not being completed and reviewed as required. The findings are: A. Record review of R #3's facility file revealed the following: 1. The last time her facility evaluation was reviewed was 08/19/15. 2. She was receiving services from a hospice agency and there was no documentation on an evaluation of any of the services R #3 was receiving from the Hospice agency. B. On 07/27/16 at 3:00 pm, during interview the Administrator confirmed the evaluation for R #3 had not been updated every 6 months and there was no documentation on a facility evaluation of the Hospice services.	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.	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 026	Continued From page 20 B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that the resident Individual Service Plan (ISP) for 1 (R #3) of 3 (R#s 1-3) residents records reviewed for timeliness, accuracy, and detail met the requirements. This deficient practice has the potential for the residents to not receive the appropriate care and assistance they need as changes in their health status occurs due to the ISPs not being completed in detail and reviewed as required. The findings are: A. Record review of the ISP for R #3 revealed	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 026	Continued From page 21 the following: 1. One page of specifics for the services being provided by a Hospice provider dated 04/29/16 with no signatures to signify it was reviewed by a licensed nurse; 2. One year between the last two reviews signed by a Licensed Nurse on 02/25/15 with one new entry dated 02/17/16 with initials. B. On 07/27/16 at 3:00 pm, during an interview with the Administrator, she confirmed that the ISP for R #3 did not give specifics on services provided by the Hospice agency and was not reviewed at least every 6 months as required.	A 026		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 034	Continued From page 22 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 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	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 034	Continued From page 23 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 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:	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 034	Continued From page 24 Refer to 7.8.2.34 A. (1, 3, & 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 anestizing 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 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 all of the facility's 15 (R #s 1-15) residents as identified on the resident census list provided by DCS #4 on 07/20/16, by: 1. not locking the storage of residents'	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 034	Continued From page 25	A 034		

medication compartments, and
2. not insuring the Consulting Pharmacist reviewed the medication quarterly (every 3 months) as required.
3. not storing oxygen cylinders properly in a rack and failed to store them in a ventilated storage area.

This deficient practice could lead to medications to be stolen, tampered with, being administered to a resident or someone it is not prescribed for, could lead to discrepancies in the medication regimen, and in the event of a fire or a 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 07/21/16 at 1:50 pm, during a tour of the facility, the medication cart, the narcotics box, and the medication refrigerator for medications were observed to be unlocked.

B. On 07/21/16 at 1:50 pm, during an interview with DCS #11, he confirmed the medications were not locked and the narcotics are only locked after shift change.

C. Record review of the Consulting Pharmacist medication regimen reviews revealed they were reviewed on 11/23/15 and not again until 04/20/16; a period of 5 months.

D. On 07/27/16 at 11:30 am, during a tour of the facility with DCS #11, the following were observed stored in resident room six which is occupied by R #1 and not a ventilated storage area:
1. six 24 cubic foot oxygen bottles in a rack;
2. seven 9 cubic foot oxygen bottles in a rack;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 034	Continued From page 26 3. one 24 cubic foot oxygen bottle not in a rack and free standing; and 4. two 9 cubic foot oxygen bottles not in a rack and free standing. E. On 07/27/16 at 11:30 am, during an interview with DCS #11 while touring the facility, he confirmed that oxygen tanks were stored in a resident's room (Room #6), which is not ventilated. F. On 07/27/16 at 3:00 pm, during an interview with the Administrator, she acknowledged the Consulting Pharmacist had not reviewed the medication regimen every 3 months as required.	A 034		
A 043	7 NMAC 8.2.43 Hazardous Areas HAZARDOUS AREAS: Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than one hundred (100) sq. ft., storage rooms more than fifty (50) sq. ft. but less than one hundred (100) sq. ft. not storing combustibles, storage rooms with more than one hundred (100) sq. ft. storing combustibles, chemical storage rooms with more than fifty (50) sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either: (1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter (3/4) hour rating; or (2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or	A 043		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 043	Continued From page 27 (3) other hazardous areas shall be enclosed with walls with at least a twenty (20) minute fire rating and doors equivalent to one and three-quarter (1 3/4) inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. Boiler, furnace or fuel fired water heater rooms. For facilities with four (4) or more residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one (1) hour. Doors to these rooms shall be one and three-quarter (1-3/4) inch solid core. [7.8.2.43 NMAC - Rp, 7.8.2.44 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.43 A. (1) & B. Based on observation and interview, the facility failed to ensure that penetrations and holes in hazardous areas (water heater rooms, furnace rooms, and laundry) in the fire rated walls and ceilings were properly sealed with approved fire suppression material and failed to have automatic door closures and latches in working order. This deficient practice presents a risk to all 15 (R #s 1-15) residents identified on the Resident Census List provided by DCS #4 on 07/20/16 and all occupants of the building from smoke and fire passing through the fire rated wall in the event of a fire. The findings are: A. On 07/27/16 at 11:00 am, during a tour of the facility with DCS #11, the following was observed: 1. There were several penetrations and holes through the walls and ceilings of 2 of the	A 043		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 043	Continued From page 28 fuel fired hot water heater (WH) rooms (WH room #1 and #3). 2. WH #1 did not have a self closing device or a latch on the fire rated door. 3. There were several penetrations and holes through the fire walls and ceilings of the 2 fuel fired furnaces (F #1 and #2) rooms. 4. F #2 had a door self closing device that did not close the door sufficiently for the door to latch. 5. The facility's laundry room had several penetrations and holes through the fire walls and ceilings. The door to this room had a door latch that did not latch. B. On 07/27/16 at 11:30 am, in an interview with DCS #11 while touring the facility, he confirmed the holes and penetrations in the water heater rooms and furnace rooms and that the automatic door closures did not latch in F #2, WH #1 and in the laundry room.	A 043		
A 044	7 NMAC 8.2.44 Heating, Air-Conditioning and Ventilation HEATING, AIR-CONDITIONING AND VENTILATION: A. Heating, air-conditioning, piping, boilers and ventilation equipment shall be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities shall have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. B. The heating method used by the facility shall provide a minimum temperature of seventy (70) degrees fahrenheit, measured at three (3) feet above the floor, in all rooms used by the	A 044		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 044	Continued From page 29 residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device shall be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances shall be permanently anchored and kept away from flammables such as curtains, bedcovering, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or presents danger from electrical shock. D. Fireplaces and open flame heating shall not be utilized in sleeping rooms. E. Gas fired water heaters shall not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms. F. The facility shall be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means. G. All openings to the outside air used for ventilation shall be screened for the control of insects and rodents. Screen doors shall be equipped with self-closing devices. H. The facility shall have a system for maintaining the residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7.8.2.44 NMAC - Rp, 7.8.2.45 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.44 G. Based on observation and interview the facility failed to screen double doors (French doors) that	A 044		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 044	Continued From page 30 were being used for ventilation. This deficient practice could lead to insect infection of the facility which could affect the health and safety of all 15 (R #s 1 - 15) residents in the facility. The findings are: A. On 07/26/16 at 7:25 am, during tour of the facility, the double doors in the library were observed to be standing open. The doors had no screens to protect from insect infestation. B. On 07/26/16 at 8:08 am, during tour of the facility, the double doors in the library were observed to be standing open. The doors had no screens to protect from insect infestation. C. On 07/27/16 at 9:50 am, during tour of the facility, the double doors in the library were observed to be standing open. The doors had no screens to protect from insect infestation. D. On 07/27/16 at 9:55 am, in an interview with DCS #4, she confirmed the double doors in the library were standing open and the door openings were not screened.	A 044		
A 048	7 NMAC 8.2.48 Electrical System ELECTRICAL SYSTEM: A. All fuse and breaker boxes shall be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility shall know the location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances shall be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear.	A 048		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 048	Continued From page 31 (2) Extension cords shall not be used. The use of a multi-socket united laboratories approved (U/L APPROVED) surge protector with integrated circuit breaker no greater than six (6) feet in length is permitted for the intended purpose and not as an extension cord. [7.8.2.48 NMAC - Rp, 7.8.2.49 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.48 C. (2) Based on observation and interview the facility failed to ensure a multi-socket electrical adaptor was a surge protector and approved by United Laboratories (U/L). This deficient practice could lead to a fire which could harm all 15 (R #s 1 - 15) residents as identified by the resident census list provided by DCS #4 on 07/20/16, and all occupants of the building. The findings are: A. On 07/20/16 at 10:00 am, during tour of the facility, a multi-socket electrical adaptor was observed in the West office. It was not a surge protector and approved by U/L. B. On 07/27/16 at 11:30 am, during an interview with DCS #11, he acknowledged the multi-socket electrical adaptor in the West office was not a surge protector and approved by U/L.	A 048		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction.	A 063		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 063	Continued From page 32 A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.63 A. (3) Based on observation and interview, the facility failed to annually maintain all portable fire extinguishers in accordance with NFPA 10 Standard for Portable Fire Extinguishers. This failed practice may result in the failure of the portable fire extinguishers to operate, in the event of a fire. This has the potential to harm all 15 (R #s 1 through 15) residents as identified by the census list provided by DCS #4 on 07/20/16 and all other occupants of the building. The findings are: A. On 07/27/16 at 11:00 am, during tour of the facility, it was observed all portable fire extinguishers had not been serviced or inspected since May of 2014 by an authorized contractor	A 063		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 063	Continued From page 33 and, not inspected monthly by staff. B. On 07/27/16 at 11:30 am, during an interview with DCS #11 while touring the facility, he confirmed the fire extinguishers had not been serviced annually by an authorized contractor and, not inspected monthly by staff.	A 063		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.65 A. & B. (2) Based on record review and interview, the facility	A 065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 065	Continued From page 34 failed to conduct the following: 1. fire drills on each shift for each quarter for the past year; and 2. monthly fire drills. This failed practice may result in the staff not being prepared to carry out a safe evacuation of residents and notification of the fire department in the event of a fire. This has the potential to harm all 15 (R #s 1 through 15) residents as identified on resident list provided by DCS #4 on 07/20/16 and all occupants of the building. The findings are: A. Record review of the facility's fire drill records revealed the following: 1. For the months of January 2016, February 2016 and March 2016: a drill was missed on the night shift. 2. For the months of April 2016 there was no fire drill 3. For August through December 2016: a drill was missed on the night shift. B. On 07/27/16 at 3:00 pm, during interview, the Administrator confirmed that the fire drills were not completed for each month or during the night shift from 10:00 pm to 6:00 am for the months of January 2016 through March 2016 and for August through December 2016.	A 065		
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to "	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 068	Continued From page 35 DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6)	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 068	Continued From page 36 months or less to live. (8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services;	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 068	Continued From page 37 and (g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 068	Continued From page 38 with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 068	Continued From page 39 authority shall be notified. E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.68 B. (1 & 2) Based on record review and interview the facility failed to ensure that 4 (DCS #s 1, 2, 3 and 4) of 17 (DCS #s 1-17) Direct Care Staff reviewed for training had the following: 1. A minimum 6 hours annual training for staff of palliative/hospice care, including 1 hour specific to the hospice resident's ISP; 2. offer an ongoing employee psychological support program for end of life care issues; 3. 1 (R # 3) of 1 (R #3) resident reviewed for hospice services had an Individual Service Plan (ISP) that has what services the hospice agency is	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 068	Continued From page 40 providing for the resident. This deficient practice increases the potential to negatively impact the health, safety, and welfare of residents receiving hospice services by staff not knowing the proper methods of providing care to protect Hospice residents from illness, injury, or harm. The findings are: A. Record review of staff records for DCS #1 had a hire date of 10/14/15 and there was documentation that the DCS received 6 hours of annual training of palliative/hospice care training, no documentation of 1 hour specific to the hospice resident's ISP; and there was no documentation of an ongoing employee psychological support program for end of life care issues. B. Record review of staff records for DCS #2 with a hire date of 03/07/16, revealed no documentation of any hospice training and there was no documentation of an ongoing employee psychological support program for end of life care issues. C. Record review of staff records for DCS #3 with a hire date of 06/12/14, revealed the following: 1. No documentation that the DCS received 6 hours of training in the past year of palliative/hospice care training and no documentation of 1 hour specific to the hospice resident's ISP; and 2. No documentation of an ongoing employee psychological support program for end of life care issues. D. Record review of staff records for DCS #4 with a hire date of 10/10/10, revealed the following:	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(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 068	Continued From page 41 1. No documentation that the DCS received 6 hours of training of palliative/hospice care training in the past year, no documentation of 1 hour specific to the hospice resident's ISP; and 2. No documentation of an ongoing employee psychological support program for end of life care issues. E. On 07/27/16 at 9:30 am, during interview, DCS #15 acknowledged there was no further documentation for the staff training or an ongoing psychological support program for end of life care issues. F. Record review for R #3 revealed an ISP that did not have any of the services listed that the hospice agency was providing. G. On 07/27/16 at 3:00 pm, during interview, the Administrator confirmed that the ISP for R #3 did not have any of the services listed that the hospice agency was providing.	A 068		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC.	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 42 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: Refer to 7.8.2.70 D. Refer to 7.1.9.8 G. 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: . . . D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the department of public safety and the federal bureau of investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 43 seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. . . . E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The department and department of public safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico department of health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant , caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by department of public safety and the federal bureau of investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department.	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 44 F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Refer to 7.8.2.70 E. Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 45	A 070		

registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.
A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.
B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.
C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry.
D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 46	A 070		

prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.
E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.
F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.
[7.1.12.8 NMAC - N, 01/01/2006]

Based on record review and interview, the facility failed to ensure that 10 (DCS #s 1, 2, 4, 5, 6, 7, 8, 9, 11 and 12) of 17 (DCS #s 1-17) Direct Care Staff (DCS) met the requirements for the following:
1. Employee Abuse Registry (EAR) inquiry prior to date of hire for DCS #s 1, 2, 4, 5, 6, 7, 9, 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 47 and 12 records reviewed; 2. Caregiver Criminal History Screening (CCHSP) within 20 days of the date of hire for DCS #s 4, 5, 7, 8 and 11 records reviewed for CCHSP. This deficient practice has the potential to affect all 15 (R #s 1-15) residents as identified on the resident census list provided by DCS #4 on 07/20/16 by allowing a person who has been convicted of a felony or who has been placed on the EAR for Abuse, Neglect, and/or Exploitation to have access to all residents. The findings are: A. Record review findings related to Employee Abuse Registry (EAR) inquiry: 1. DCS #1's staff records revealed a date of hire as 10/20/15 and inquiry to the EAR was not completed until 11/17/15. 2. DCS #2's staff records revealed a date of hire as 10/13/15 and inquiry to the EAR was not completed until 01/21/16. 3. DCS #4's staff records revealed a date of hire as 04/11/16 and inquiry to the EAR was not completed until 05/03/16. 4. DCS #5's staff records revealed a date of hire as 06/22/16 and inquiry to the EAR was not completed until 07/06/16. 5. DCS #6's staff records revealed a date of hire as 05/09/16 and inquiry to the EAR was not completed until 06/23/16. 6. DCS #7's staff records revealed a date of hire as 02/19/14 and inquiry to the EAR was not completed. 7. DCS #9's staff records revealed a date of hire as 04/25/16 and inquiry to the EAR was not completed until 07/06/16. 8. DCS #11's staff records revealed a date of hire as 03/07/16 and inquiry to the EAR was not completed until 06/20/16. 9. DCS #12's staff records revealed a date of	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 48 hire as 06/20/16 and inquiry to the EAR was not completed until 06/24/16. B. Record review findings related to Caregiver Criminal History Screening (CCHSP): 1. DCS #4's date of hire was 04/11/16, however, the application and fingerprinting were not sent to CCHSP until 05/24/16. 2. DCS #5's date of hire was 06/22/16, however, the fingerprinting was not completed for CCHSP until 07/18/16. 3. DCS #7's date of hire was 02/19/14, however, there were no application, fingerprinting, or clearance letter for CCHSP in the records. 4. DCS #8's date of hire was 07/07/16, however, there were no application, fingerprinting, or clearance letter for CCHSP in the records. 5. DCS #11's date of hire was 03/07/16, however, the fingerprinting was not completed for CCHSP until 07/15/16. C. On 07/21/16 at 10:00 am, in an interview with DCS #4, she acknowledged some of the facility staff records did not have EAR or CCHSP records and some were done later than the required time limits. Refer to 7.6.2.10 G. G. Ventilation: (1) All rooms shall have sufficient ventilation, as determined by the Health Authority, to keep them reasonably free of excessive heat, steam, condensation vapors, obnoxious odors, smoke fumes, grease vapor, and dust. (2) Obnoxious odors, cooking fumes and vapors shall be effectively vented to the outside and shall be discharged in a manner that will not create a nuisance.	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 49 (3) Exhaust hoods, or other ventilation devices required by applicable codes shall be designed, installed, and maintained to prevent grease or condensate from dripping into food or onto food preparation surfaces. Filters shall be kept clean and in good repair. (4) Clean-out openings of sufficient size and number shall be provided into the horizontal exhaust ducts serving exhaust hoods over cooking areas. Intake and exhaust ducts shall be designed and maintained to prevent the entrance and accumulation of noxious fumes, dust, dirt, rodents, insects, or other contamination materials. [7.6.2.10 NMAC - Rp, 7 NMAC 6.1.301 to 307, 08/12/2000] 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. 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 15 (R #1 through 15)	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 50 residents as identified by the resident census list provided by DCS #4 on 07/20/16 by not having the following: 1. Documentation the cooking exhaust system was cleaned quarterly; 2. Documentation the fire suppression system in the cooking exhaust system had been inspected annually and semi-annually. This deficient practice could lead to a grease fire in the cooking exhaust system and for the fire suppression system in the cooking exhaust system to fail in the event of a fire, putting residents and all other occupants of the building in danger. The findings are: A. On 07/27/16 at 9:20 am, during a tour of the facility there was a sticker on the cooking exhaust system signifying it had been cleaned on 07/05/16 and the next cleaning was due on 07/20/17. B. Record review of facility inspection records revealed the fire suppression system in the cooking exhaust system was inspected and serviced on 05/07/14 and no other records were available; therefore no documentation they were inspected annually and semi-annually. C. Record review of facility inspection records revealed the cooking exhaust system was cleaned on 07/14/15 and not again until 07/05/16; therefore no documentation it was cleaned bi-annually (every 6 months). D. On 07/27/16 at 9:30 am, during an interview with DCS #15, she acknowledged there was no documentation of bi-annual cleaning of the cooking exhaust system and no documentation of the fire suppression system in the cooking	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	2049		C 07/27/2016

NAME OF PROVIDER OR SUPPLIER
MILLIE'S ASSISTED LIVING COMMUNITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HUDSON STREET
SILVER CITY, NM 88061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 51 exhaust system had been serviced since 05/07/14.	A 070		