STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2161	A. BUILDING: _____ B. WING _____	01/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE TRAMWAY RIDGE	4910 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

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A 000	Initial Comments The following deficiencies were cited during a Full Onsite survey completed on 01/27/20, for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.	A 000		
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 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	A 016		

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A 016	Continued From page 1 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 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:	A 016		

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A 016	Continued From page 2 7.8.2.16 B (3) (7) 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 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	A 016		

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A 016	Continued From page 3 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 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.	A 016		

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A 016	Continued From page 4 [7.1.12.8 NMAC - N, 01/01/2006] 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 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	A 016		

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A 016	Continued From page 5	A 016		

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.

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

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A 016	Continued From page 6	A 016		

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.

Based on record review and interview, the facility failed to ensure that:
1. All Direct Care Staff (DCS) providing care and services had been cleared by the Employee Abuse Registry (EAR) prior-to-hire.
2. The applications and fingerprints for the Caregiver Criminal History Screening program (CCHSP) were submitted within 20 days of the date of hire.

This deficient practice could likely result in all 13 (R #s 1-13) residents identified on the census provided by the Director of Nursing (DON) on 01/21/20, to be at risk of being provided care by DCS who may have a previous history of abusing, neglecting, and/or exploiting residents. The findings are:

A. Record review of DCS #2's employee file & staff listing, hire date 05/23/07, revealed no documentation that:
1. An EAR application was submitted, and clearance received prior to hire.
2. CCHSP was not submitted within 20 days

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A 016	Continued From page 7 of hire. B. On 01/27/20 at 2:00 pm, during an interview with the Office Manager (OM), she confirmed that DCS #2's file contained no documentation: 1. That an EAR application was submitted, and clearance received prior to hire. 2. The CCHSP application and fingerprints were submitted within 20 days of hire.	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;	A 017		

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A 017	Continued From page 8 (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 A. B. C. (6-8) (12) Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS) received all required supervised, orientation, and annual trainings. This deficient practice could likely result in all 13 (R #s 1-13) residents identified on the census provided by the Director of Nursing, (DON) on 01/21/20, to be at risk of harm or injury, if staff have not received training on the methods of providing care and services. The findings are: A. Record review of DCS #1's (hire date 11/14/19) staff file revealed no documentation of receiving the following trainings: 1. Sixteen (16) hours of supervised training before providing unsupervised care. 2. Orientation & proof of competency of the following trainings: a. Resident rights.	A 017		

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A 017	Continued From page 9 b. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. c. Smoking policy for staff, residents and visitors. d. The proper way to implement a resident ISP. B. Record review of DCS #2's (hire date 05/23/07) staff file revealed no documentation of receiving the following trainings: 1. Sixteen (16) hours of supervised training before providing unsupervised care. 2. Annual training: a. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. b. Smoking policy for staff, residents and visitors. c. The proper way to implement a resident ISP. C. Record review of DCS #3's (hire date 09/13/19) staff file revealed no documentation of receiving the following trainings: 1. Sixteen (16) hours of supervised training before providing unsupervised care. 2. Orientation & proof of competency of the following trainings: a. Smoking policy for staff, residents and visitors. b. The proper way to implement a resident ISP. D. On 01/27/20 at 2:00 pm, during an interview with the Office Manager (OM), she confirmed that DCS #1-3 file contained no documentation of the trainings & activities listed above.	A 017		

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A 025	Continued From page 10	A 025		
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; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance	A 025		

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A 025	Continued From page 11 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 A B E Based on record review and interview the facility failed to ensure for 3 (R #s 1-3) of 3 (R #s 1-3) residents whose Evaluations/Assessments were reviewed for compliance that they were: 1. Completed within 15-days prior to admission. 2. Reviewed and/or updated at a minimum of every 6-months or change in condition by a Licensed Practical Nurse (LPN), Registered Nurse (RN), or Physicians Extender (PE). 3. Reviewed when the Individual Service Plans (ISPs) were reviewed.	A 025		

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A 025	Continued From page 12 This deficient practice could likely result in negatively affect the health and safety of all residents by not receiving needed care and services if the evaluations: 1. Were not completed prior to admission, so that residents are ensured of receiving the appropriate level of care and/or that the facility could provide the level of care needed for each resident. 2. Had not been reviewed and if needed updated at a minimum of every 6 months or when a change in condition occurred. 3. Were not reviewed when the ISP was revised. The findings are: A. Record review of R #1's resident file revealed no documentation that: 1. An evaluation was completed 15-days prior to [redacted] admission to the facility [redacted]/18. 2. The evaluations were reviewed at a minimum of every 6-months or when a change of condition occurred. 3. The evaluations were reviewed when the ISP was revised on 01/30/18, 09/30/18, 07/27/19 or 08/30/19 B. Record review of R #2's initial Evaluation/Assessment dated 10/24/17 revealed no documentation that the evaluations were: 1. Updated at a minimum of every 6 months from [redacted] admission to the facility on [redacted]/17. 2. Reviewed/updated when ISPs were revised on 05/21/18, 07/23/18, 06/06/19 or 07/25/19. C. Record review of R #3's initial Evaluation/Assessment dated 06/13/19 revealed	A 025		

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A 025	Continued From page 13 no documentation that the evaluation was: 1. Updated at a minimum of every 6 months or upon a change in condition from his admission to the facility on 06/13/19. 2. Reviewed/updated when ISPs were revised on 07/17/19 or 11/19/19. D. On 01/27/20 at 2:30 pm, during an interview with the Director of Nursing, (DON), she confirmed the Evaluation/Assessment findings listed above for R #s 1-3.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be	A 026		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 026	Continued From page 14 provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (3) Based on record review and interview, the facility failed to ensure for 3 (R #s 1-3) of 3 (R #s 1-3) residents whose Individual Service Plans (ISPs) were reviewed for compliance were: 1. Developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. 2. Reviewed and/or revised at a minimum of every six (6) months. This deficient practice could likely result in all residents to be at risk of harm or injury if Direct Care Staff (DCS) are not providing the correct care/services needed, if the ISPs were not completed within 10 days of admission and/or reviewed/revised at a minimum of every six months, because they do not know what changes to the residents care/services have been made.	A 026		

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A 026	Continued From page 15 The findings are: A. Record review of R #1's resident file revealed that the: 1. Initial ISP dated 01/30/18 was not completed within 10 days of admission on [redacted]/18. 2. ISPs dated 09/30/18 & 07/27/19 were not revised/updated at a minimum of every 6 months. B. Record review of R #2's resident file revealed that the: 1. Initial ISP dated 05/21/18, was not completed within 10 days of admission on [redacted]/17. 2. ISPs dated 07/23/18 and 06/06/19, were not revised/updated at a minimum of every 6 months. 3. ISPs dated 05/21/18, 07/23/18, 06/06/19 & 07/25/19, had no signatures to confirm review by appropriate staff, resident or surrogate decision maker. C. Record review of R #3's resident file revealed that the initial ISP dated 07/17/19 was not completed within 10 days of R #3's admission to the facility on [redacted]/19. D. On 01/27/20 at 2:30 pm, during an interview with the Director of Nursing, (DON), she confirmed the findings above regarding resident ISPs for R #1-3.	A 026		
A 030	7 NMAC 8.2.30 Handling of Resident Funds HANDLING OF RESIDENT FUNDS: A. Each resident has the right to manage their personal funds in accordance with state or	A 030		

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A 030	Continued From page 16 federal laws. B. If the facility agrees, the resident may entrust his or her personal funds to the facility for safekeeping and management. In such cases, the facility shall: (1) have written authorization from the resident or his or her surrogate decision maker; (2) maintain a written record of all financial transactions and arrangements involving the resident's funds and make this written record available upon request, to the resident, his or her surrogate decision maker and the licensing authority; (3) safeguard any and all funds received from the resident in an account separate from all other funds of, or held by, the facility; (4) upon written or verbal request by the resident or his or her surrogate decision maker, return to the resident all or any part of the resident's funds given to the facility for safekeeping and management, including all accrued interest if applicable; and (5) upon the resident's death, will transfer all personal funds held by the facility to the resident ' s estate in accordance with Section 45-3-709 NMSA 1978. C. The facility shall not commingle the resident ' s funds, valuables or property with that of the licensee. Resident ' s funds, valuables or property shall be maintained separate, intact and free from any liability of the licensee, staff and management. [7.8.2.30 NMAC - Rp, 7.8.2.31 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.30 B (1)	A 030		

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A 030	Continued From page 17 Based on interview, the facility failed to ensure for 3 (R #s 1-3) of 3 (R #s 1-3) resident files review for compliance that the facility obtained written consent to oversee resident funds This deficient practice could likely result in all residents to be at risk of being exploited or their monies being mismanaged if the facility does not have consent to manage the resident's funds. The findings are: A. Record review of R #s 1-3 resident records revealed, no signed consent forms on file for the facility to handle their funds. B. On 01/27/20 at 2:00 pm, during an interview with the Office Manager (OM), she confirmed that the facility does handle/maintain resident personal funds for R #s 1-3 and does not have written agreements/consents to manage resident's funds.	A 030		
A 031	7 NMAC 8.2.31 Handling of Emergencies HANDLING OF EMERGENCIES: A. Upon admission, each resident or surrogate decision maker shall designate a primary care practitioner (PCP) to be called in case of a medical necessity. Each resident or representative shall also designate a concerned person to be called in case of an emergency. The facility shall establish a policy to secure medical assistance if the resident's own physician is not available. In the event of an illness or an injury to the resident, the PCP or a physician extender shall be notified by the facility. B. The facility shall have a first aid kit that contains at a minimum, gauze, adhesive tape, antiseptic ointment and bandages for	A 031		

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A 031	Continued From page 18 emergencies. The first aid kit shall be kept in a designated, easily accessible place within the facility. C. An easily accessible and functional telephone shall be available in each facility for summoning help in case of an emergency. A pay telephone does not fulfill this requirement. D. A list of emergency numbers including: fire department, police department, ambulance services and poison control shall be posted near each public telephone in the facility. [7.8.2.31 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.31 D Based on observation and interview, the facility failed to ensure that a list of emergency phone numbers (fire, police, ambulance, poison control, etc.) were posted by the public telephones used by staff, residents, families and/or visitors. This deficient practice could likely result in all 13 (R #s 1-13) residents identified on the census provided by the Director of Nursing, (DON), on 01/21/20, to be at risk of delayed response from emergency services and to potentially not receive needed first aid/medical treatment, timely. The finding(s) are: A. On 01/21/20 at 3:10 pm, during an observation of the facility, no emergency numbers (fire, police, ambulance, poison control, etc) were observed to be posted near public telephones in the facility located in the dining areas of each of the 4 neighborhoods.	A 031		

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A 031	Continued From page 19 B. On 01/27/20 at 12:15 pm, during an interview with the Administrator, she confirmed emergency numbers (fire, police, ambulance, poison control, etc) were not posted near the public phones in the facility used by staff, residents, families and/or visitors in the dining areas of each of the 4 neighborhoods.	A 031		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and	A 032		

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A 032	Continued From page 20 (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an	A 032		

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A 032	Continued From page 21	A 032		

incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form.

Based on record review and interview, the facility failed to ensure that incidents of unusual occurrence, falls which cause injury, an unexpected death, or elopement (leave without the facility being aware), were reported to the Licensing Authority within twenty-four (24) hours or the next business day if on a holiday or weekend. This deficient practice could likely result in all 13 (R #s 1-13) Memory Care Unit (MCU) residents identified on the census provided by the Director of Nursing, (DON) on 01/21/20, to be at risk of harm, injury, and/or death, if there is no oversight by the Licensing Authority, because the facility failed to report these incidents within 24 hours or the next business day if a holiday or weekend. The findings are:

A. Record review of facility's incident report log from 11/22/19 - 01/22/20 revealed:

1. That on 01/17/20 at 7:30 pm, Direct Care Staff (DCS #5) reported (unknown if witnessed or not witnessed) that R #4 fell in the hallway resulting in a [redacted] which was confirmed by X-rays. The family was contacted but refused further medical treatment for the [redacted]

2. There was no documentation of the incident being reported to the Licensing Authority within 24 hours or the next business day if a holiday or weekend regarding R #4's fall resulting in [redacted]/20.

B. Record review of facility's incident report log

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A 032	Continued From page 22 from 11/22/19 - 01/22/20 revealed: 1. That on 01/11/20 at 11:30 am, DCS #6 reported that R #5 was found face down on the floor in [redacted] bedroom with a head injury, bruising, abrasion, and skin tear. The facility (unnamed nurse) evaluated R #5 took vitals and recommended head injury be evaluated. The facility called 911 & Power of Attorney (POA), but POA refused further treatment or care at a hospital. 2. There was no documentation of the incident being reported to the Licensing Authority within 24 hours or the next business day if a holiday or weekend regarding the R #5's unwitnessed fall resulting in a head injury occurring on 01/11/20. C. Record review of facility's incident report log from 11/22/19 - 01/22/20 revealed: 1. That on 01/07/20 at 4:45 pm, DCS #3 reported that R #6 called out after an apparent fall resulting in injury (skin tear at right elbow). 2. No documentation of the incident being reported to the Licensing Authority within 24 hours or the next business day if a holiday or weekend regarding the skin tear resulting from a fall on 01/07/20. D. Record review of facility's incident report log from 11/22/19 - 01/22/20 revealed: 1. That on 12/06/19 at 5:50 pm, DCS #6 reported that R #9 had eloped from the facility and was found outside in the parking lot trying to open a car door and that [redacted] may have followed staff out the door. R #9 was checked for injury and was in no apparent distress or pain. 2. No documentation of the incident being reported to the Licensing Authority within 24 hours or the next business day if a holiday or weekend regarding R #9's, elopement 12/06/19.	A 032		

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A 032	Continued From page 23 E. On 01/27/20 at 2:30 pm, during an interview with the DON, she confirmed the Internal Incident Reports contained no documentation that the above incidents were reported to the Licensing Authority within twenty-four (24) hours or the next business day if on a holiday or weekend.	A 032		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program.	A 033		

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A 033	Continued From page 24 D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without	A 033		

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A 033	Continued From page 25 unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety	A 033		

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A 033	Continued From page 26 of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 C D (9) Based on record review, observation and interview the facility failed to ensure that the: 1. Resident rights were posted in a conspicuous public place in the facility that included the telephone numbers for the Incident Management Hotline and for the State Ombudsman Program. 2. Telephones were located or could be taken to a private area by residents allowing them to have private conversations. This deficient practice could likely result in all 13 (R #s 1-13) residents identified on the census provided by the Director of Nursing, (DON), on 01/21/20, to be at risk of 1. Injury or harm due to not understanding their rights to report incidents or complaints to the Licensing Authority or State Ombudsman's office who provide facility oversite. 2. Having personal and private conversations overheard by staff and visitors. The findings are: Findings related to posting resident rights A. On 01/21/20 at 3:40 pm, during observation of the facility revealed there were no Residents	A 033		

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A 033	Continued From page 27 Rights posters with the telephone numbers for the Incident Management Hotline and the State Ombudsman Program displayed in a conspicuously place in the facility. B. On 01/21/20 at 3:40 pm, during an interview with the Administrator, she confirmed the facility had not the Resident's Rights posters including the phone numbers for the Incident Management Hotline and the State Ombudsman Program displayed in a conspicuously place in the facility. Findings related to private phone conversations: C. On 01/21/20 at 3:40 pm, during an observation phones were observed to be available for resident use in each of the dining rooms attached to the wall preventing residents from having private phone conversations. D. On 01/21/20 at 3:43 pm, during an interview with the Administrator, she confirmed the phones available for resident use are located in the dining areas attached to the wall preventing residents from having private phone conversations.	A 033		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications	A 034		

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A 034	Continued From page 28 for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs;	A 034		

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A 034	Continued From page 29 (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications.	A 034		

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A 034	Continued From page 30 (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A Based on observation, record review and interview, the facility failed to ensure for 2 (R #s 2-3) of 3 (R #s 1-3) residents whose medications were reviewed for availability were on hand and available for residents. This deficient practice could likely result in all residents being at risk of harm, illness, or death if residents are not taking medications as ordered by a physician, because they are unavailable. The findings are: A. Record review of R #2's [redacted]/20 - [redacted]/20, Medication Administration Records, (MAR), revealed the following medications listed on the MAR were not located in the medication cart or refrigerator: [redacted]	A 034		

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A 034	Continued From page 31 [redacted] B. Record review of R #3's [redacted]/20 - [redacted]/20, MAR revealed: [redacted] C. On 01/24/20 at 2:30 pm, DCS #s 1 & 6 confirmed the medications listed above for R #s 2 & 3 were not present in the medication cart or refrigerator.	A 034		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies	A 036		

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A 036	Continued From page 32 and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes:	A 036		

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A 036	Continued From page 33 (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware.	A 036		

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A 036	Continued From page 34 (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a	A 036		

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A 036	Continued From page 35 three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated	A 036		

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A 036	Continued From page 36 room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2. 36. A (1) (d) C (4) D (4)	A 036		

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A 036	Continued From page 37	A 036		

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

1. All garbage and kitchen refuse are kept in watertight containers with close-fitting lids.

2. Weekly menus were posted where residents and families are able to view it ensuring special diets are provided for and weekly menus do not repeat the same meal.

3. Food temperatures are periodically checked to maintain a minimum temperature of hot foods at 140 degrees Fahrenheit.

This deficient practice could likely result in all 13 (R #s 1-13) residents identified on the census provided by the Director of Nursing, (DON) on 01/21/20:

1. To be at risk of potential harm from contracting of illnesses from bacteria/germs.

2. Of not being made aware of meals or snacks available to residents during the week ensuring properly planned meals, diets, and special diets are available for resident's freedom of choice.

3. To be at risk of harm if the facility does not periodically check food temperatures ensuring that a minimum of one hundred forty (140) degrees Fahrenheit is maintained.

The findings are:

Regarding trash bins and menu:

A. On 01/21/20 at 11:00 am, during observation in the Southeast kitchen/dining area, the garbage container available for waste from meal services did not have a close-fitting lid.

B. On 01/21/20 at 3:40 pm, during observation of facility, revealed that the facility failed to ensure weekly menus were posted where residents,

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A 036	Continued From page 38	A 036		

family, and visitors can see them and be aware of menu choices for the week.

C. On 01/27/20 at 12:15 pm, during an interview with the Administrator, she confirmed that:

1. The garbage container in the Southeast kitchen/dining area did not have a close-fitting lid on it.

2. There were no weekly menus posted in the facility for where residents, family and visitors can see them to be aware of the food choices for the week.

Regarding food temperatures:

D. On 01/23/20 at 11:58 am, during observations & record review revealed:

1. Meals were brought from the main facility in a heated server cart from the main facility approximately 100 yards away.

2. Staff did not take temperature of the food being served to ensure a minimum temperature of one hundred forty (140) degrees Fahrenheit was maintained during transport from the main building to the memory care unit.

3. No documentation that food temperatures are periodically checked to ensure a minimum temperature of hot foods is maintained at 140 degrees Fahrenheit.

E. On 01/23/20 at 11:58 am, during an observations and interview:

1. Direct Care Staff, (DCS), #2 was observed serving meals to residents from the heated cart used to transport food from the main building to the memory care unit residents' meals.

2. DCS #2, confirmed when asked, she stated that the staff does not check the food temperature before serving it to residents in the memory care unit.

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A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.42 A Based on observation and interview, the facility failed to ensure that the walls and ceilings were in good condition with no damage or drywall penetrations (holes). This deficient practice could likely result in all 13 (R #s 1-13) residents identified on the census provided by the Director of Nursing, (DON) on 01/21/20, to be at risk of harm, injury, or death if a fire were to occur. The findings are: A. On 01/21/20 at 2:50 pm, during observation of the storage closet in the Southeast neighborhood revealed a penetration (hole in the drywall) approximately 25" X 37" in the common wall between the dining room sink and storage room.	A 042		

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BROOKDALE TRAMWAY RIDGE	4910 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 042	Continued From page 40 B. On 01/21/20 at 3:04 pm, during observation of the Southeast dining area revealed: 1. A penetration (hole in the drywall) approximately 2"x 2" at the half wall between the dining room and main corridor. 2. A penetration (hole in the drywall) approximately 5"x 9" under the kitchen sink. C. On 01/21/20 at 3:25 pm, during observation in the electrical room in the kitchen area revealed: 1. No drywall on the ceiling approximately 6' X 13' with exposed insulation, electrical conduit and pipes. 2. Stored items blocking access to control panels included: a. A large drop cloth over a 5-gallon bucket or paint. b. 3 empty boxes. c. 2 tables d. 1 broken end table. e. 1 plumber's snake (tool used for clearing out clogged drains). f. 1 metal easel (upright device used for display) as identified by the Administrator. D. On 01/21/20 at 3:30 pm, during observations in the Northwest neighborhood dining area revealed: 1. A penetration (hole in the drywall) underneath the sink approximately 2' x 2'. 2. Water damage and mold on the wall underneath the sink. E. On 01/21/20 at 3:39 pm, during observation of the Northeast kitchen/dining area revealed a penetration (hole in the drywall) approximately 1'x 1' underneath the sink and electrical outlet not closed into the wall. F. On 01/27/20 at 12:15 pm, during an interview	A 042		

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A 042	Continued From page 41 with the Administrator, she confirmed the observations/findings listed above in Southeast, Northeast and Northwest neighborhood areas and in the electrical room.	A 042		
A 050	7 NMAC 8.2.50 Exits EXITS: A. The facility shall have at least two (2) approved exits, that do not involve windows and which are remote from each other. B. Facilities with ten (10) or more residents shall have each exit clearly marked with lighted signs having letters at least six (6) inches high and at least three-quarters (3/4) of an inch wide. Exit signs shall be visible at all times. C. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. D. Exits shall be clear of obstructions at all times. E. Exits, exit paths, or means of egress shall not pass through hazardous areas, garages, storerooms, closets, utility rooms, laundry rooms, bedrooms, or spaces subject to locking. F. For facilities with four (4) or more residents, sliding doors are not acceptable as a required exit. EXCEPTION: Assisted living facilities with three (3) or fewer residents may have sliding doors as required exits. G. When the yard gate(s) is part of the exit access and is locked, the gate shall be connected to the fire protection system and release upon activation of the fire/smoke system or shall have the ability to be unlocked at the gate site. [7.8.2.50 NMAC - Rp, 7.8.2.51 NMAC, 01/15/2010]	A 050		

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A 050	Continued From page 42 This REQUIREMENT is not met as evidenced by: 7.8.2.50 (B) Based on observation and interview, the facility failed to ensure that the North emergency exit sign was illuminated. This deficient practice could likely result in all 13 (R #s 1-13) residents listed on the census provided by Director of Nursing (DON) on 01/21/20 and all occupants to be at risk of injury or harm if they are unable to safely evacuate the building in case of a fire or other emergency that requires evacuation, because they cannot see where the exit doors are. The findings are: A. On 01/23/20 at 1:23 pm, during observation of the North emergency exit revealed that the exit sign was not illuminated, and when tested it still did not light up. B. On 01/27/20 at 12:15 pm, during an interview with the Administrator, she confirmed the exit sign at the North emergency exit was not illuminated and did not light up when tested.	A 050		
A 052	7 NMAC 8.2.52 Corridors CORRIDORS: A. Corridors in an existing building shall have a minimum width of thirty-six (36) inches. Corridors in newly constructed facilities shall have a minimum width of forty-four (44) inches. B. Corridors shall have a clear ceiling height of not less than seven (7) feet measured to the lowest projection from the ceiling. C. Corridors shall be maintained clear and free of obstructions at all times. D. The floors of corridors and hallways shall be	A 052		

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A 052	Continued From page 43 waterproof, greaseproof, smooth, slip-resistant and durable. [7.8.2.52 NMAC - Rp, 7.8.2.53 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.52 C. Based on observation and interview, the facility failed to ensure that the corridors were kept clear and free of obstructions at all times. This deficient practice could likely result in all 13 (R #s 1-13) residents identified on the census provided by the Director of Nursing, (DON) on 01/21/20, if the corridors are blocked and do not allow residents easy access in the corridors to safely exit the building in case of fire or other emergency requiring evacuation. The findings are: A. On 01/22/20 at 10:45 am, during observation at the Northeast neighborhood, a large furniture cabinet was observed obstructing the corridor in the Southern most hallway that goes from resident rooms to the emergency exit route. B. On 01/27/20 at 12:15 pm, during an interview with the Administrator, she confirmed the large furniture cabinet was obstructing the South corridor of the Northeast neighborhood leading from those resident rooms to the emergency exit route.	A 052		
A 061	7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT:	A 061		

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A 061	Continued From page 44 A. Fire alarm system. Facilities with four (4) or more residents shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction. B. Smoke and heat detection. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining and living room(s) must also be provided with smoke detectors. (1) Detectors shall be powered by the house electrical service and have battery back up. (2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room. (3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service. [7.8.2.61 NMAC - Rp, 7.8.2.60 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2 61. B (3-4) Based on observation and interview, the facility failed to ensure that: 1. A heat detector was installed in the kitchen area. 2. Smoke detectors were installed in corridors or main gathering areas. This deficient practice could likely result in all 13 (R #s 1-13) residents identified on the census provided by the Director of Nursing (DON) on	A 061		

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A 061	Continued From page 45 01/21/20, to be at risk of injury by fire/smoke if the smoke and heat detectors are not installed and a fire were to occur. A. On 01/21/20 from 1:45-3:40 pm, during observation of the main corridor revealed, no smoke detectors were installed. The corridor was observed to be more than 30 feet in length. B. On 01/21/20 from 1:45-3:40 pm, during observation of the four (4) dining areas, no smoke detectors were observed to have been installed in any of these main gathering areas. C. On 01/21/20 at 3:20 pm, during observation of the kitchen area (only dining area with a stove), revealed it had no heat detector installed. D. On 01/27/20 at 12:15 pm, during interview with the Administrator, she confirmed that there were no smoke detectors in the main corridor (which exceeds 30 feet in length), no smoke detectors in any of the dining rooms, and no heat detector in the kitchen area.	A 061		
A 062	7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Facilities with nine (9) or more residents shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. [7.8.2.62 NMAC - Rp, 7.8.2.61 NMAC, 01/15/2010]	A 062		

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A 062	Continued From page 46 This REQUIREMENT is not met as evidenced by: 7.8.2.62 National Fire Protection Agency (NFPA) 13.6.2.7.1 Plates, escutcheons, or other devices used to cover annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. Based on observation and interview, the facility failed to ensure the automatic fire sprinkler system had the sprinkler heads maintained throughout the facility. This deficient practice of not maintaining the automatic sprinkler system could cause the system being unreliable for extinguishing fire and could likely result in all 13 (R #s 1-13) residents identified on the census provided by the Director of Nursing (DON) on 01/21/20, and all building occupants to be at risk of harm, injury, or death, if a fire were to occur, because the sprinkler system may not work properly. The findings are: A. On 01/21/20 at 3:00 pm, during an observation and tour of the facility, revealed that the escutcheons (plate covers) around the sprinkler heads were missing or in ill repair in the Southeast quadrant dining room, in the office adjacent to the Southwest quadrant dining room and in the kitchen. B. On 01/27/20 at 12:15 pm, during an interview with the Administrator, she confirmed the escutcheon were either missing or improperly fitted around multiple sprinkler heads located in the Southeast dining room, in the office adjacent to the Southwest dining room, and in the kitchen.	A 062		

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A 063	Continued From page 47	A 063		
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. 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: 7.8.2.63 B. Reference NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition: 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.	A 063		

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A 063	Continued From page 48 Based on observation and interview, the facility failed to ensure that the fire extinguishers were being inspected annually or monthly as recommended by the manufacturer. This deficient practice could likely result in all 13 (R #s 1-13) residents identified on the census provided by the Director of Nursing (DON) on 01/21/20, and all building occupants to be at risk of harm, injury, or death, if a fire were to occur, and the fire extinguishers do not work. The findings are: A. On 01/21/20 at 3:20 pm, during observation of the fire extinguisher in the fire sprinkler control room revealed: 1. The last annual inspection was in October of 2017. 2. No documentation of monthly inspections as recommended by the manufacturer. B. On 01/22/20 at 8:20 am, during observation of the four (4) fire extinguishers in the main corridor had no documentation of monthly inspections as recommended by the manufacturer. C. On 01/27/20 at 12:15 pm, during an interview with the Administrator, she confirmed that fire extinguishers in the facility have not been inspected as detailed in the above findings.	A 063		
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following	A 068		

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A 068	Continued From page 49 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) months or less to live.	A 068		

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A 068	Continued From page 50 (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; and	A 068		

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A 068	Continued From page 51 (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 with information on palliative care and shall	A 068		

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A 068	Continued From page 52 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 authority shall be notified.	A 068		

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A 068	Continued From page 53 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: 7.8.2.68 B (1) Based on record review and interview, the facility failed to ensure that Direct Care Staff, (DCS) received a minimum of six (6) hours per year of palliative/hospice care training including one (1) hour specific to the resident. This deficient practice could likely result in the 3 (R #s 3, 4 & 10) hospice residents identified on the census provided by the Director of Nursing, (DON) on 01/21/20, as receiving hospice care to be at risk of not receiving the proper care if the DCS have not received training on the methods of providing care and services to hospice residents. The findings are.	A 068		

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A 068	Continued From page 54 A. Record review of DCS #2's (hire date 05/23/07) staff file revealed she had not received a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice residents. B. On 01/27/20 at 2:00 pm, during an interview with the Office Manager (OM), she confirmed that DCS #2 's staff file contained no documentation of receiving six (6) hours per year of palliative/hospice care training including one (1) hour specific to hospice residents.	A 068		
A 069	7 NMAC 8.2.69 Memory Care Units MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions: The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply. (1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer ' s gets progressively worse and is fatal. (2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services. (3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain.	A 069		

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A 069	Continued From page 55 (4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program. (5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit. B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process. (1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services. (2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside health care provider. C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information. D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC,	A 069		

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A 069	Continued From page 56 pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria: (1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs; (2) 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. E. Assessments and reevaluations. (1) An assessment shall be completed by a registered nurse or a physician extender within fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5) days after admission. (a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission. (b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the	A 069		

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A 069	Continued From page 57	A 069		

need for the resident to reside in a memory care unit.
(c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted.
(2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident ' s stay in the assisted living facility memory care unit is still appropriate.
F. Documentation in the resident ' s record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record:
(1) the physician ' s diagnosis for admission to a secure environment or a memory care unit;
(2) the pre-admission assessment; and
(3) the re-evaluation(s).
G. Secured environment.
(1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to:
(a) double alarm systems;
(b) gates connected to the fire alarm; and
(c) tab alarms for residents at risk for elopement.
(2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents.
(a) Fencing or other enclosures shall prevent

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A 069	Continued From page 58 elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident ' s legal representative, if applicable and prior to the resident ' s admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for. (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1)	A 069		

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A 069	Continued From page 59 trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.69 C D E (1) (b-c) F (1) G (2) (b) Based on record review and interview the facility failed to ensure that: 1. Direct Care Staff, (DCS), received a minimum of twelve (12) hours of training per year related to dementia, Alzheimer's disease, or other pertinent information. 2. A team meeting in coordination with the resident's Primary Care Provider, (PCP), as described in "Exceptions to admission, readmission and retention," Subsection C of 7.8.2.20 NMAC in creating Individual Service Plans, (ISPs) for residents in this memory care facility was convened. 3. A pre-admission assessment including written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment was completed. 4. A physician's diagnosis for admission to a secure environment or a memory care unit was obtained. 5. Residents are able to independently access the outdoor areas. This deficient practice could likely result in all 13 (R #s 1-13) residents identified on the census provided by the Director of Nursing (DON) on 01/21/20, to be at risk of: 1. Not receiving the individual (physical, mental, social) care and services needed if the DCS have not completed the required 12-hours of annual specialized Dementia/Alzheimer's training.	A 069		

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A 069	Continued From page 60 2. Not receiving appropriate care if an ISP is not created in coordination with the resident's PCP identifying the resident's specific needs for care within a secured memory care unit. 3. Placement in a secured memory care unit inappropriately, against their will or if their PCP has not determined the placement is needed for personal safety due to Alzheimer's and other related dementia behaviors. 4. A loss of a sense of personal independence if residents are restricted from accessing the secure outdoor area independently given the secured environment of the facility. Findings related to Alzheimer's/Dementia Care specific training A. Record review of DCS #2's (hire date 05/23/07) staff file revealed she had not received a minimum of twelve (12) hours of training per year related to dementia, Alzheimer's disease, or other pertinent information. B. On 01/27/20 at 2:30 pm, during an interview with the Office Manager (OM), she confirmed that DCS #2's staff file contained no documentation of receiving twelve (12) hours of training per year related to dementia, Alzheimer s disease, or other pertinent information. Regarding team meeting and ISPs. C. Record review of R #1's ISP's dated 01-30-18, 09-30-18, 07-27-19 or 08-30-19, revealed no documentation of a team meeting being convened in coordination with the resident's Primary Care Provider, (PCP), as described in "Exceptions to admission, readmission and retention," Subsection C of 7.8.2.20 NMAC.	A 069		

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A 069	Continued From page 61 D. Record review of ISPs created for R #2's on 05/21/18, 07/23/18, 06/06/19 or 07/25/19, revealed no documentation of a team meeting in coordination with the resident's Primary Care Provider, (PCP), as described in "Exceptions to admission, readmission and retention," Subsection C of 7.8.2.20 NMAC. E. Record review of R #3's resident file revealed no documentation of a: 1. Pre-admission assessment that included written findings for basis for the admission to the secured environment. 2. Physician's order for placement in a memory care/secured unit. 3. Of a team meeting in coordination with the resident's Primary Care Provider, (PCP), as described in "Exceptions to admission, readmission and retention," Subsection C of 7.8.2.20 NMAC in the ISPs created on 07/17/19 or 11/19/19. F. On 01/27/20 at 2:30 pm, during an interview with the Director of Nursing, (DON), she confirmed the files contained no documentation of: 1. A team meeting in coordination with the resident's Primary Care Provider, (PCP), as described in "Exceptions to admission, readmission and retention," Subsection C of 7.8.2.20 NMAC for R #3's 1-3 as indicated above. 2. A pre-admission assessment that included written findings, an evaluation of less restrictive alternatives, and the basis for the admission to the secured environment for R #3. 3. Physician's orders stating the need for placement in a memory care unit for R#3. Regarding independently accessing outdoor area:	A 069		

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A 069	Continued From page 62 G. On 01/23/20 at 1:23 pm, an observation of the North exit: 1. The door requires a code entered into the keypad to open this exit door that allows entry into the secured outdoor area of the facility. 2. The outdoor area is secured and does not allow exit into public ways. 3. All residents have a diagnosis of Alzheimer's disease or other dementia. H. On 01/27/20 at 12:15 pm, during an interview with the Administrator, she confirmed that; 1. The North exit door allowing entry to the secured outdoor area requires a code be entered into a key pad to access the area. 2. All residents in this facility have a diagnosis of Alzheimer's disease or other dementia. 3. Due to memory deficits, the residents in the facility do no retain the capacity to remember the access code or operate the keypad allowing them to independently access the secure outdoor area.	A 069		