

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  5686	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 05/12/2015
NAME OF PROVIDER OR SUPPLIER  ARISTOCRAT ASSISTED LIVING (THE)		STREET ADDRESS, CITY, STATE, ZIP CODE 2969 CLAUDE DOVE DRIVE LAS CRUCES, NM 88011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments  A complaint investigation was completed for intake NMO0029633 on 05/12/15 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was unsubstantiated with deficiencies cited as a result of the investigation.  Deficiencies were cited due to discovery during the survey.	A 000		
A 021	7 NMAC 8.2.21 Resident Records  RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician's assistant and shall be on file in the resident's record within ten (10) days of admission; (5) personal and demographic information for the resident, to include:	A 021		

*Scanned  
08-06-15  
J.D.  
2nd  
Set*

Division of Health Improvement  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Marilyn Sundson*

TITLE

*Director*

(X6) DATE

*7/30/15*

STATE FORM

6899

UKX211

If continuation sheet 1 of 5

**RECEIVED**  
  
AUG 04 2015  
  
HEALTH FACILITY LICENSING  
& CERTIFICATION BUREAU

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A 021	Continued From page 1  (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list, and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident, entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may	A 021			

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A 021	Continued From page 2  be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility, and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions.	A 021			

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A 021	Continued From page 3  [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010]  This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.21 A. (7)  Based on record review and interview the facility failed to include documentation provided by caregivers of services provided to the residents related to the Individual Service Plans (ISPs) for 4 (R #1-4) of 4 resident records reviewed. This widespread deficient practice could lead to caregivers and others responsible for providing care for the residents to not know what care other caregivers have or have not provided to the residents and to not know if there has been a change in the residents condition and needs. The findings are:  B. Record review of records for Residents R #1-4, revealed no entries by caregivers with significant information related to the ISP for 4 of 4 (R #1-4) residents R #1, R #2, R #3, and R #4.  A. On 05/08/15 at 11:10 am, during an interview with the Administrator, she acknowledged the facility nurse writes the notes on record for each resident and the caregivers do not write notes about the residents.  Refer to 7.8.2.21 B. (1)  Based on record review and interview the facility failed to keep/maintain Caregiver "Assignment Sheet," specific to resident needs for 40 of 40 (R	A 021	<b>1. 7.8.2.21A(7)</b>  <b>Care and services provided by caregivers for each resident as identified in the ISP will be documented on the Daily Service Delivery Record on each shift to make certain that care and service needs have been met and changes in resident needs and services have been communicated.</b> <b>Notes reflecting changes in resident care needs will be noted by the Clinical Manager and adjustments will be made to the resident's ISP.</b> <b>The Director and Clinical Manager will review and monitor the established process in monthly Quality Assurance reviews for three months.</b>		

*Reviewed  
6/25/15  
(on form)*

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A 021	Continued From page 4  #1 through R #40) residents that reside in the facility. This widespread deficient practice could lead to changes in the Residents needs over a period of time to go unnoticed. The findings are:  A. Record review of the staff assignment sheets for Residents R# 1 through R #40 revealed only the month of April and May 2015 were available. These assignment sheets listed which residents were assigned to each Caregiver with information as to each residents care needs. Some of the assignment sheets had notes from the Caregiver of changes and/or additional needs that residents needed during their shifts.  B. On 05/08/15 at 11:10 am, during an interview with the Administrator, she acknowledged the facility uses assignment sheets for staff that are turned in after their shift, but they are only kept for 2 months and discarded. She further acknowledged that sometimes the Caregivers enter notes related to a Resident's care needs on those assignment sheets before they turn them in.	A 021	<b>2. 7.8.2.21.B (1)</b>  <b>Caregiver Assignment Sheets will be maintained on the premises for a period of five years. Notes related to care and services provided by caregivers for each resident as identified in the ISP will be documented on each shift on the Daily Service Delivery Record to make certain that care and service needs have been met and changes in resident conditions have been communicated.</b>  <b>The Director and Clinical Manager will review and monitor established process in monthly Quality Assurance Review for three months.</b>	<i>5/12/15</i>  <i>6/25/15</i> <i>Training (update form)</i>	