

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2171	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER RETREAT (THE)		STREET ADDRESS, CITY, STATE, ZIP CODE 4075 JACKIE RD SE RIO RANCHO, NM 87124		
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A 000	Initial Comments The following deficiencies were cited during a Full-Onsite/Complaint conducted on 05/05/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Deficiencies were cited as result of the survey. NM#55455 unsubstantiated with no deficiencies cited NM#45355 unsubstantiated with no deficiencies cited NM#58393 unsubstantiated with no deficiencies cited	A 000		7/30/22
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;	A 026		

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

Melina R. Spiers

TITLE

Administrator

(X6) DATE

6/10/22

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A 026	<p>Continued From page 1</p> <p>(4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.26 B (7) (9)</p> <p>Based on record review and interview, the facility failed to ensure for 10 (R #s 1-10) of 10 (R #s 1-10) residents whose Individual Service Plans (ISP's) were reviewed for compliance included:</p> <ol style="list-style-type: none"> 1. Expected outcomes. 2. The level of assistance the resident requires with transfers/mobility. <p>These deficient practices could likely negatively effect the safety and welfare of the residents, if the Direct Care Staff (DCS) do not know what the:</p> <ol style="list-style-type: none"> 1. Resident's expected outcomes are. 2. Level of assistance and number of DCS needed with transfers and mobility. <p>The findings are:</p>	A 026		

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A 026	Continued From page 2 Findings related to goals and outcomes. A. Record review of R #1's ISP dated 04/06/22, revealed no documentation of any outcomes for the resident. B. Record review of R #2's ISP dated 08/31/21, revealed no documentation of any outcomes for the resident. C. Record review of R #3's ISP dated 12/09/21, revealed no documentation of any outcomes for the resident. D. Record review of R #4's (deceased) ISP dated 01/21/20, revealed no documentation of any outcomes for the resident. E. Record review of R #5's (deceased) ISP dated 08/10/21, revealed no documentation of any outcomes for the resident. F. Record review of R #6's ISP dated 12/19/21, revealed no documentation of any outcomes for the resident. I. Record review of R #7's ISP dated 04/26/22, revealed no documentation of any outcomes for the resident. J. Record review of R #8's ISP dated 12/14/21, revealed no documentation of any outcomes for the resident. K. Record review of R #9's ISP dated 02/09/22, revealed no documentation of any outcomes for the resident. L. Record review of R #10's ISP dated 11/29/21,	A 026	7 NMAC 8.2.26: The facility since its opening in 2010 has maintained care plans that identified needs and strengths, appropriate interventions, related/expected outcomes and the responsible discipline. The facility utilizes a computer-generated care plan design that embeds the outcomes within the text of the interventions making the "outcomes" difficult to identify. As of 6/15/22, the ISPs for all residents identified by the surveyor (#1-10) will have an additional column identified specifically for "Outcomes" so that nursing staff can clearly identify outcomes of interventions. A nurse manager has been assigned as of 6/1/22 to begin a quality assurance review of all care plans to identify any "outcomes" that may be currently embedded within the text of other care plan areas (interventions). By 7/30/22 all facility care plans will have an additional column identified as "Outcomes" with the appropriate information added for each resident in the newly created "Outcomes" column. Nursing staff will reassess all care plan interventions quarterly to identify "outcomes" that can be added or adjusted to the newly designated area. The facility will continue to do a fuller reassessment every 6 months as has been the procedure and make appropriate updates to the "Outcomes" area.	7/30/22

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A 026	<p>Continued From page 3</p> <p>revealed no documentation of any outcomes for the resident.</p> <p>M. On 05/05/22 at 11:30 am, during an interview with the Facility Owner, she confirmed that ISP's for R #s 1-10 did not include any outcomes.</p> <p>Findings Regarding Level of Assistance Requirements</p> <p>N. Record review R #7's ISP dated 04/26/22, stated that R #7 was independent in bed mobility and ambulation and supervision as needed for transfers.</p> <p>O. On 04/28/22 at 9:02 am, during an observation, R #7 was observed to require assistance from two DCS (DCS #17 and DCS #18), to move [REDACTED]</p> <p>P. On 05/05/22 at 9:05 am, during an interview, DCS #16 confirmed that R #7 intermittently requires a 2-person assist with transfers/mobility. DCS #16 stated that sometimes R #7 can ambulate or move on [REDACTED]</p> <p>R. On 05/05/22 at 11:30 am, during an interview, the Facility Owner confirmed that R #7's ISP indicates that [REDACTED] is marked as independent and does not include R #7's need for a 2-person assistance with transfers/mobility due to the fluctuation (changes) in [REDACTED]</p>	A 026	<p>7 NMAC 8.2.26 Continued</p> <p>Resident #7 was reassessed by the nursing team and there continued to be consensus that the resident demonstrated variability with levels of dependence with activities of daily living secondary to a fluctuating cognitive status. This "fluctuating level of dependence with ADLs" has been clearly identified on the care plan as of 5/12/22 with appropriate interventions that address the fluctuating needs by the direct care staff to provide assistance as needed.</p> <p>On 5/6/22 and 5/11/22 a nursing meeting was held for all licensed staff (RN and LPNs) with a focus on care plans, assessments, and specifically on the appropriate ways to assess, document, and care plan residents that have varying levels of ADL needs due to their fluctuating cognitive capacity. This additional training prepared the licensed staff to better communicate in assessments and on the facility's care plans this unique aspect of resident function often seen in dementia.</p> <p>Nurse Managers will be specifically focused on their quality assurance reviews (quarterly) to check for appropriate language, description, and care plan interventions for those residents with this unique ADL fluctuation related to cognitive instability.</p>	
A 034	<p>7 NMAC 8.2.34 Custodial Drug Permits</p> <p>CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to</p>	A 034		

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A 034	Continued From page 4 this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery 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	A 034		5/31/22

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A 034	<p>Continued From page 5</p> <p>for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99.</p> <p>(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:</p> <p>(a) the type and strength of the schedule II through IV drugs;</p> <p>(b) the date and time staff assisted with self-administration;</p> <p>(c) the resident ' s name;</p> <p>(d) the prescriber ' s name;</p> <p>(e) the dose;</p> <p>(f) the signature of the person assisting with delivery of the medication; and</p> <p>(g) the balance of medication remaining.</p> <p>(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.</p> <p>(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.</p> <p>B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance.</p> <p>(1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the</p>	A 034		

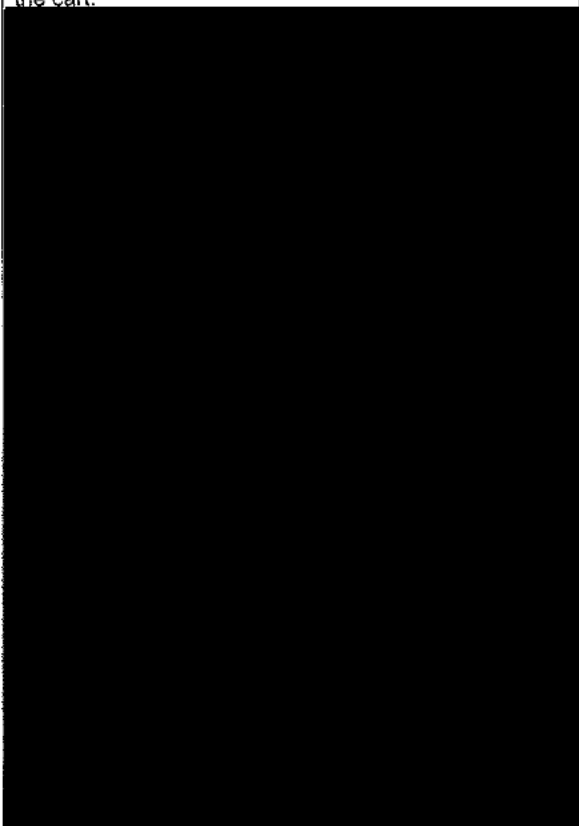
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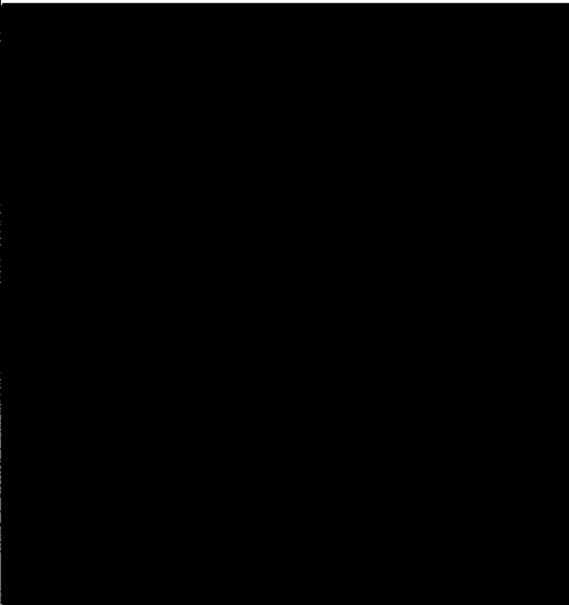

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A 034	<p>Continued From page 6</p> <p>administrator within seventy-two (72) hours.</p> <p>(2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation.</p> <p>(3) Consultation shall be provided 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.</p> <p>(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]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.34 A 4</p> <p>Based on record review, observation, and interview the facility failed to ensure:</p> <ol style="list-style-type: none"> 1. All medications, including non-prescription drugs, were stored in a locked compartment or in a locked room, as approved by the board of pharmacy. 2. All physician ordered medications for residents were available for use. <p>These deficient practices could likely result in the residents being at risk of harm, injury, or death if:</p> <ol style="list-style-type: none"> 1. Unsecured self-administered medications are stored in unlocked cart were readily accessible to other residents, staff, or visitors. 2. Residents were to miss doses or treatment because the medications prescribed by the physicians were not available. 	A 034		

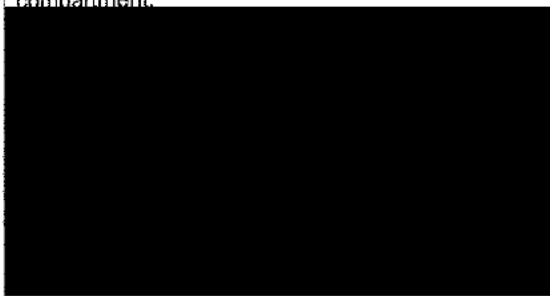
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A 034	Continued From page 7 The findings are The findings related to the unlocked medication storage are: A. On 04/28/22 at 8:49 am, during observation of the facility's kitchenette, the following medications were observed in an unsecured open and unlocked 5-drawer treatment medication cart. 1. The following medications were found in the cart: 	A 034	7 NMAC 8.2.34 The facility maintains locking medication and treatment carts for medication and treatment supply storage. It is the policy and practice of the facility nursing staff to lock each cart when not present with the cart and to keep the cart keys on their person during their shift. The nurses identified by the survey team were reminded and educated to the facility practice and requirement of maintaining a locked medication and treatment cart on the day of survey. In addition, on 5/6/22 and 5/11/22 all nurses participated in a training meeting that specifically reviewed this policy and procedure to increase compliance to this requirement. Nurse Managers from 5/11/22 – 5/31/22 checked medication and treatment carts during their daily rounds to ensure that there was 100% compliance with this requirement. Nurse Managers will continue to intermittently "spot check" nursing carts on their environmental inspections. The safety committee of the facility also provides for monthly environmental inspections. Beginning on 7/1/22, the safety committee review will include a "spot check" of all medication and treatment carts during their inspection for compliance to this requirement.	5/31/22

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A 034	<p>Continued From page 8</p>  <p>2. The following non-medication items that were found in the cart include:</p>  <p>B. On 05/05/22 at 11:30 am, during an interview, the Administrator confirmed that the medications</p>	A 034		

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A 034	Continued From page 9 and supplies listed above were not being stored in a locked or secure place. The findings related to missing/unavailable medication. C. Record review of R #3's Medication Administration Record (MAR) dated 04/01/22 through 05/02/22, revealed that the following 6 medications (prescription dated 04/28/22) were listed on the MAR, but were not in the medication compartment:  D. On 05/02/22 at 12:11 pm, during observation of the medication cart for R #3, the six (6) medications listed on the MAR above were not found in the medication compartment. E. On 05/02/22 at 12:50 pm, during an interview, Direct Care Staff (DCS) #15 confirmed that the 6 medications listed above on R #3's MAR, were not available in the medication cart.	A 034	7 NMAC 8.2.34 Continued: A review was completed by the facility Nurse Managers by 5/3/22 to assure that all residents had all medications and PRN medications for each resident within the facility. Resident #3 had all her PRN medications delivered to the facility by 5/3/22. There were no regularly scheduled medications missed. Nurse Managers will be responsible for ordering all PRN and regularly scheduled medications to the facility upon admission (Resident #3 was a new admission). The facility notified the consultant pharmacist of the noted violation so that the quarterly review done by Pharmacy will include a quality assurance check that all medications are present for all residents during the pharmacy review.	5/3/22
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations	A 038		

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A 038	<p>Continued From page 10</p> <p>of dirt, rubbish and dust.</p> <p>A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment.</p> <p>B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms.</p> <p>C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.38 C</p> <p>Based on observation and interview, the facility failed to ensure that poisonous/harmful substances, chemicals, and cleaning supplies were stored in secure areas, not accessible to residents.</p> <p>This deficient practice could likely result in the 55 (R #s 1-55) residents listed on the census provided by the Administrator on 04/28/22, to be at risk of harm, injury, or death if residents were to ingest or spill the substances on them self or others.</p> <p>The findings are:</p>	A 038	<p>7 NMAC 8.2.38:</p> <p>The facility has a strong and successful history of maintaining chemicals in appropriate storage areas. The Ice-Melt was immediately removed on the day of survey to an appropriate storage area by the maintenance manager. In addition, the full administrative team was provided an educational session on 5/10/22 on the dangers of chemicals in unlocked or unauthorized areas. The full administrative team (whose members also serve on the safety committee) will continue to monitor the facility for compliance to this standard during regular rounds of the facility and during the monthly safety committee environmental walk through.</p>	5/10/22

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A 038	Continued From page 11 A. On 04/28/22 at 8:49 am, during observation of the facility, (1) 5-Gallon Ice Melt was found in the unlocked kitchenette in the faith unit. B. On 04/28/22 at 10:13 am, during an interview, the Administrator of the facility confirmed that the kitchen is accessible to the residents and the presence of the chemical.	A 038		