STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	09/14/2018

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A 000	Initial Comments The following deficiencies were cite during a Full-Onsite/Complaint survey completed on 09/20/18 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint Intake #'s NM#30637, NM#30663, NM#30717, and NM#31900 were substantiated with deficiencies cited. Class " B" deficiencies were called for the following citations: A019-Staffing Ratio A035-Medication A049-Doors A051-Separation of Sleeping Rooms A064-Fire Safety, Equivalency Rating	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;	A 016		

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A 016	Continued From page 1 (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 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	A 016		

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A 016	Continued From page 2 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: 7.8.2.16 A (4) 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	A 016		

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A 016	Continued From page 3 provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee 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	A 016		

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A 016	Continued From page 4 the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] 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	A 016		

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A 016	Continued From page 5 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 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	A 016		

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A 016	Continued From page 6 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 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.	A 016		

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A 016	Continued From page 7 Based on record review and interview the facility failed to ensure that 2 (DCS #s 1, 3) of 3 (DCS #s 1-3) Direct Care Staff that: 1. Direct Care Staff (DCS) had been cleared by the Employee Abuse Registry (EAR) prior-to-hire. 2. The application and fingerprints for the Caregiver Criminal History Screening program (CCHSP) were submitted within 20 days of the date of hire. 3. The Administrator had completed a state approved Administrator's course. This deficient practice has the potential to affect the safety and welfare of all residents if: 1. They are being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents or have a felony conviction. 2. The Administrator has no documentation of completing a state required Administrators course. The findings are: Findings related to EAR/CCHSP: A. Record review of DCS #1's (hire date: 02/05/17) employee file revealed, that the EAR was submitted on 11/21/17, not prior to hire. There was missing documentation for CCHSP/fingerprinting. B. Record review of DCS #3's (hire date: 07/20/18) employee file revealed, that the EAR was not submitted prior to hire on file at the facility. There was missing documentation for CCHSP fingerprints	A 016		

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A 016	Continued From page 8 C. On 09/11/18 at 1:15 pm, during an interview with the Administrator, she confirmed that the EAR were not submitted for DCS #s 1 and 3 prior to hire. She also confirmed that there was missing documentation in DCS #s 1 and 3 employee files and that their fingerprints were submitted within 20 days of hire on file at the facility. Findings related to Administrators certificate: D. Record request for the Administrator's certificate of completion of a state approved certification course for Administrators revealed, no documentation of her certificate of completion on file at the facility. E. On 09/19/18 at 11:20 am, during an interview with the Administrator, she confirmed that she cannot find her certificate of completion of a state approved Administrator's course.	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;	A 017		

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A 017	Continued From page 9 (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (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 (1-3) (a-e) (4-12) Based on record review and interview, the facility failed to ensure for 3 (DCS #s 1-3) of 3 (DCS #s 1-3) Direct Care Staff whose training files were reviewed for compliance received the required: 1. 16-hours of supervised training prior to	A 017		

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A 017	Continued From page 10 providing unsupervised care. 2. 12-hours of orientation and annual training. This deficient practice has the potential for all residents to be at risk of harm or injury if staff have not received training on the proper methods of providing care, and services. The findings are: A. Record review of DCS #s 1-3 staff files revealed, missing documentation for orientation/annual and supervision trainings for: 1. 16-hours of supervised training prior to providing unsupervised care. 2. Fire safety and evacuation training. 3. First aid. 4. Safe food handling practices (for persons involved in food preparation), to include a. Instructions of proper storage. b. Preparation and serving food. c. Safety in food handling. d. Appropriate personal hygiene. e. Infectious and communicable disease control. 5. Confidentiality of records and resident information. 6. Infection control. 7. Residents rights 8. Reporting requirements for abuse, neglect, or exploitation in accordance with 7.1.13 NMAC. 9. Smoking policy for staff, residents,and visitors; 10. Methods to provide quality resident care; 11. Emergency procedures; 12. Medication assistance, including the certificate of training for staff that assist with medication delivery; 13. The proper way to implement a resident ISP for all staff that assist with Individual Service	A 017		

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A 017	Continued From page 11 Plans (ISPs). B. On 09/11/18 at 1:15 pm, during an interview with the Administrator, she confirmed that DCS #s 1-3 did not have fire safety and evacuation training.	A 017		
A 018	7 NMAC 8.2.18 Policies POLICIES: The facility shall have and implement written personnel policies for the following: A. staff, private duty attendant and volunteer qualifications; B. staff, private duty attendant and volunteer conduct; C. staff, private duty attendant and volunteer training policies; D. staff and private duty attendant and volunteer criminal history screening; E. emergency procedures; F. medication administration; G. the retention and maintenance of current and past personnel records; and H. facilities shall maintain records and files that reflect compliance with NM and federal employment rules. [7.8.2.18 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.18 A-G Based on record review and interview, the facility failed to have written personnel policies for the following:	A 018		

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A 018	Continued From page 12 1. Staff, private duty attendant, and volunteer qualifications. 2. Staff, private duty attendant, and volunteer conduct. 3. Staff, private duty attendant, and volunteer training policies. 4. Staff, private duty attendant, and volunteer criminal history screening. 5. Emergency procedures. 6. Medication administration. 7. Retention and maintenance of personnel records. This deficient practice could cause harm to all 7 (R #s 2,3,5-9) residents, identified on the census provided by Administrator on 09/11/18, by having staff not trained or aware of the correct way to implement facility's policy's and procedures that affect the safety and welfare of the residents. The findings are: A. Record review of the facility's Policies and Procedures manual revealed, that the following required policies and procedures were missing: 1. Staff, private duty attendant, and volunteer qualifications. 2. Staff, private duty attendant, and volunteer conduct. 3. Staff, private duty attendant, and volunteer training policies. 4. staff, private duty attendant, and volunteer criminal history screening. 5. Emergency procedures. 6. Medication administration. 7. Retention and maintenance of personnel records. B. On 09/13/18 at 12:00 pm, during an interview with the Administrator, she confirmed that the	A 018		

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A 018	Continued From page 13 policies and procedures were missing.	A 018		
A 019	7 NMAC 8.2.19 Staffing Ratios STAFFING RATIOS: The following staffing levels are the minimum requirements. A. The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents ' needs. (1) During resident waking hours, facilities shall have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents. (2) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty, awake and responsible for the care and supervision of the residents. (3) During resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises. (4) During resident sleeping hours, facilities with thirty-one (31) to sixty (60) residents shall have at least two (2) direct care staff persons on duty and awake at all times and at least one (1) additional staff person immediately available on the premises. (5) During resident sleeping hours, facilities with more than sixty-one (61) residents shall have at least three (3) direct care staff persons on duty and awake at all times and one (1) additional staff person immediately available on the premises for each additional thirty (30) residents or fraction thereof in the facility. B. Upon request of the department, the facility shall provide the staffing ratios per each	A 019		

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A 019	Continued From page 14 twenty-four (24) hour day for the past thirty (30) days. [7.8.2.19 NMAC - Rp, 7.8.2.18 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.19 A Class B Deficiency On 09/12/18 at 10:00 am, a Class B Deficiency was called due to the facility not being in compliance with Fire Safety Evacuation Score (FSES) requirement of maintaining a score of "prompt". The facility Administrator was aware of the requirement (when there is no sprinkler system), but had not been completing the FSES evaluation form with each resident admission, discharge, or change in condition. When the score was calculated on 09/11/18 based on the resident evaluations completed by the Administrator, the results were a score of 4.24 (slow). The results indicated that the facility did not have enough staff on duty to safely evacuate the residents if a fire or other emergency that requires evacuation. The Administrator was informed of the Class B deficiency at this time. On 09/11/18 at 3:30 pm, during an interview with the Administrator, she confirmed that based on her evaluation of the residents the evacuation rating score was 4.24 which would require 3 Direct Care Staff (DCS) on duty, awake, and immediately available 24/7 to reach a "prompt" rating score. The Administrator requested that a	A 019		

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	2043	A. BUILDING: _____ B. WING _____	09/14/2018

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A 019	Continued From page 15 DCS complete the resident evacuation forms, since they know the residents better. On 09/14/18 a new FSES score was calculated based on the resident evaluations completed by the by a Direct Care Staff (DCS) and reviewed/changes made by the Administrator, the results were a rating score of 3.04 (slow). The Administrator will hire more DCS staff to ensure 2 DCS are on duty, awake, and immediately available 24/7 and a caregiver (Administrator lives on the property) nearby and immediately available. On 09/19/18 at 11:15 am, the following Plan of Removal was received and accepted. 1. The Administrator is researching the cost of a sprinkler system verses the cost of hiring more employees. 2. The Administrator is available as a second caregiver and will begin hiring more caregivers to comply with the FSES and plans to have new employee's hired by 10/15/18. 3. The FSES evaluations and rating scores will be completed at the time of admission, discharge, and any change of conditions. The Administrator was informed that the Class B Deficiency was lifted at this time. Based on record review and interview the facility failed to ensure there were enough staff scheduled/working to safely evacuate the residents if a fire or other emergency requiring evacuation were to occur. If there is not enough staff on duty at all times to safely evacuate all 7 (R #s 2, ,3, 5-9) residents listed on the resident census, provided by the Administrator on 09/11/18, from the building then they are at an increased risk of harm or death if a fire or other	A 019		

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A 019	Continued From page 16 emergency that requires evacuation should occur. The findings are: A. Record request for the facility's Fire Safety Equivalency Score (FSES) forms, revealed, there were no forms available to review. B. On 09/11/18 at 2:45 pm, during interview with the Administrator, she confirmed that there were no (FSES) forms available to review. She stated she has not used the forms in a very long time. C. Record review of the FSES forms completed by the Administrator on 09/11/18 revealed, an evacuation rating score of 4.24 (slow). D. On 09/11/18 at 3:30 pm, during an interview with the Administrator, she confirmed that based on her evaluation of the residents the evacuation rating score was 4.24 which would require 3 Direct Care Staff (DCS) on duty, awake, and immediately available 24/7 to reach a "prompt" rating score. The Administrator requested that a DCS complete the resident evacuation forms, since they know the residents better. E. Record review of the FSES forms completed by DCS #3 were reviewed/changes made by the Administrator, the evacuation score was 3.04 (slow) which would require 2 DCS on duty, awake and immediately available 24/7 and 1 DCS nearby and immediately available to reach a rating score of 1.08 (prompt). F. Record review of the DCS schedule for September 2018 revealed, there was only 1 DCS scheduled for each shift. G. On 09/19/18 at 3:30 pm, during an interview	A 019		

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A 019	Continued From page 17 with the Administrator, she confirmed that based of the FSES evacuation rating score 2 DCS will need to be on duty, awake and immediately available 24/7 and 1 DCS nearby and immediately available to "prompt" rating score of 1.08. In addition, she confirmed that the September 2018 staff scheduled revealed there was only 1 DCS scheduled to work on each shift (day/afternoon/graveyard).	A 019		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities	A 020		

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A 020	Continued From page 18 pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This	A 020		

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A 020	Continued From page 19 rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician.	A 020		

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A 020	Continued From page 20 (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed	A 020		

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A 020	Continued From page 21 provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) (8-9) (12) (b-c) (13) refer to Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal	A 020		

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A 020	Continued From page 22 belongings. B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them. C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health." SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately. Based on record review and interview the facility failed to ensure for 4 (R #s 1-4) of 4 (R #s 1-4) residents whose Admissions/Discharge Agreements were reviewed for compliance and residents who have elected to receive hospice/home health services from an outside provider included the following missing and/or incorrect information: 1. A refund provision in case of death. 2. Facility's staffing ratio 3. Written authorization for staff to assist with medications. 4. That the agreement may be terminated "if" an appropriate placement is found and there shall be a 15-day written notice of termination	A 020		

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A 020	Continued From page 23 given to the resident/surrogate decision maker. 5. The termination policy incorrectly states that the agreement can be terminated and the resident emergency discharge can occur if: a. The resident has failed to pay. b. The facility ceases to operate. 6. An admission/retention team meeting convened prior to being admitted or retained at the facility. 7. Documentation of coordination of care with the outside provider included on the Individual Service Plan (ISP). These deficient practices have the potential for residents to be at risk of: 1. The resident's estate or responsible party being unaware of any refund that may be due. 2. Being misinformed regarding the number of direct care staff that will be available to assist residents on each shift. 3. Being misinformed about the direct care staff ability to administer medications. 4. Being discharged before an appropriate placement was found and/or a 15-day written notice of termination was given to the resident/surrogate decision maker. 5. The residents are misinformed as to if/when an emergency discharge can occur. 6. Direct Care Staff (DCS) cannot provide the higher level of care the resident needed. 7. DCS do not know what care they need to provide and what care the hospice/home health agency will provide. The findings are: A. Record review of R #'s 1-4 Admissions/Discharge Agreements revealed, the following missing information:	A 020		

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A 020	Continued From page 24 1. A refund provision in case of death that complied with state statutes for prorated refund. 2. How many staff are required to be on duty during each shift throughout the day. 3. Missing documentation for direct care staff to assist with medications. 4. The admission agreement can be terminated by the facility "if" an appropriate placement has been found for the resident. 5. A 15-day written notice for termination for non payment of rent and cease to operate or is no longer able to provide services B. On 09/13/18 at 4:17 pm, during an interview with the Administrator, she confirmed that R #s 1-4 Admission/Discharge Agreements had the above listed missing/incorrect information. 7.8.2.20 C (1) D (1) C. Record review of R #s 2's resident chart revealed, no documentation of a team meeting being convened prior to being admitted to/or retained at the facility when admitted to [redacted] (date unknown). In addition, there was no documentation of coordination of care with the [redacted] on the ISP. D. Record review of R #3's resident chart revealed, no documentation of a team meeting being convened prior to being admitted to/or retained at the facility when admitted [redacted] (date unknown). E. On 09/12/18 at 4:17 pm, during an interview with the Administrator, she confirmed there was no admission/retention team meetings convened	A 020		

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A 020	Continued From page 25 prior to (R #s 2 & 3) being admitted to [redacted]. The Administrator also confirmed that there was no coordination of care with the outside provider documented on R #2's ISP.	A 020		
A 024	7 NMAC 8.2.24 Assistance with Daily Living ASSISTANCE WITH DAILY LIVING: The facility shall supervise and assist the residents, as necessary, with health, hygiene and grooming needs, to include but not limited to the following: A. eating; B. dressing; C. oral hygiene; D. bathing; E. grooming; F. mobility; and G. toileting. [7.8.2.24 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.24 G Based on record review and interviews, the facility failed to ensure for 2 (R #s 8 & 9) of 2 (R #s 8 & 9) residents that require toileting/clean-up assistance from the Direct Care Staff (DCS) were: 1. Were allowed to use the community restroom as other residents do. 2. Receive assistance with toileting/clean-up as needed. This deficient practice has the potential of harm, injury, and/or loss of dignity if residents are	A 024		

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A 024	Continued From page 26 required: 1. To use bedside commodes in their rooms. 2. To clean-up themselves and the commode without assistance from the DCS. The findings are: A. On [redacted]/18 at 3:15 pm, during an interview with R #8[redacted] stated, that [redacted] is not allowed to use the community restroom/bathroom because [redacted] and that the Administrator makes [redacted] clean [redacted] own [redacted] after use. B. On 09/19/18 at 3:20 pm, during an interview with DCS #4 she confirmed that R #s 8 & 9 are not allowed to use the community restroom/bathroom because [redacted] and that they both must clean [redacted] at the direction of the Administrator. C. On 09/20/18 at 10:30 am, during an interview with the Administrator, she confirmed that R #s 8 & 9 are not allowed to use the community bathroom in the hallway [redacted] The Administrator denied that R #s 8 & 9 were made to clean their [redacted]. D. On [redacted]/18 at 12:35 pm, during an interview with R # 9, [redacted] confirmed that he is made to clean [redacted] by staff at the direction of the Administrator.	A 024		
A 027	7 NMAC 8.2.27 Resident Activities RESIDENT ACTIVITIES: Each facility shall provide or make available recreational and social	A 027		

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A 027	Continued From page 27 activities appropriate to the residents ' abilities that meet their psychosocial needs and are relevant to their social history; including a balance of cognitive, reminiscence, physical and social activities. The facility shall post the activities and encourage residents to participate. [7.8.2.27 NMAC - Rp, 7.8.2.28 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.27 Based on observation, and interview, the facility failed to have a current activities calendar posted and/or provide activities that meet the needs of the residents. This deficient practice has the potential to affect the psychosocial well being of all 7 (R #s 2, 3, 5-9) residents identified on the census provided by Administrator on 09/13/18, [redacted] The findings are: A. On 09/13/18 at 12:00 pm, during an observation, there was no activity calendar observed to be posted in the common areas of the facility. B. On 09/13/18 at 12:00 pm, during an interview with the Administrator, she confirmed that she did not have an activities calendar because the residents did not want to do any activities.	A 027		
A 028	7 NMAC 8.2.28 Personal Possessions PERSONAL POSSESSIONS: A. Each resident shall be permitted to keep personal property in their possession at the	A 028		

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(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 028	Continued From page 28 facility, if it is not detrimental to the health and safety of anyone in the facility. These possessions may include, but are not limited to the following items: (1) clothing; the facility shall ensure that each resident has his or her own clothing; residents shall be allowed and encouraged to select their daily clothing and change their clothing to suit their activities and the weather conditions; (2) personal care items; each resident shall have his or her own personal care items such as, but not limited to, a comb, razor, hairbrush, toothbrush, toothpaste and like items. B. The facility shall have policies and procedures for identifying and safeguarding resident possessions. [7.8.2.28 NMAC - Rp, 7.8.2.29 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.28 A (1) Based on record review, observation, and interview, the facility failed to ensure that 2 (R #s 8 & 9) of 7 (R #s 2, 3, 5-9) residents residing at the facility were able to keep possession of their clothing at all times. This deficient practice has the potential for residents to not have the freedom to make their own decisions about what/when to wear their own clothing. The findings are: A. Record review of Complaint Intake (dated 06/12/18) stated, that R #8 had her clothes taken away and hidden, because [redacted] changes to often due to [redacted]	A 028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	09/14/2018

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A 028	Continued From page 29 B. On [redacted]/18 at 10:30 am, during an observation of resident [redacted] R #9's clothing was observed to not be hanging in [redacted] room. C. On 09/20/18 at 10:30 am, during an interview with the Administrator, she confirmed that R #8's clothing was taken away because [redacted] changes too much. In addition, she confirmed that R #9's clothing was taken away for the same reason.	A 028		
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 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	A 030		

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A 030	Continued From page 30 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 (1-2) C Based on record review and interview the facility failed to ensure for 3 (R #s 2-4) of 3 (R #s 2-4) resident files review for compliance that the facility: 1. Obtain written consent to oversee resident funds 2. Maintain a written record of all financial transactions. This deficient practice has the potential for all residents to be at risk of being exploited or their monies being mismanaged if the facility does not: 1. Obtain consent to manage the resident's funds. 2. Keep an accurate accounting of their monies. The findings are: A. Record review of R #s 2-4 resident records revealed, no signed consent forms on file for the facility to handle their funds.	A 030		

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A 030	Continued From page 31 B. Record review of R #s 2-4 resident records revealed, that the facility does not have a record of transactions of their funds. C. On 09/13/18 at 12:00 pm, during an interview with the Administrator, she confirmed that the facility does handle/maintain resident personal funds for R #s 2-4, does not keep any transaction/accounting records.	A 030		
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	A 032		

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A 032	Continued From page 32 form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) B 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	A 032		

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A 032	Continued From page 33 knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure incidents of abuse, neglect, and exploitation including medication errors and unusual occurrences were reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. This deficient practice has the potential for 1 (R #1) former resident and all 7 (R #s 2, 3 & 5-9) current residents listed on the census, provided by the Administrator on 09/11/18 to be at risk of harm, injury, and/or death, if there is no oversite by the Licensing Authority because the facility failed to report incidents of abuse, neglect, and exploitation including medication errors and unusual occurrence to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. The findings are: Findings related to R #1 A. Record review of a complaint Intake dated (06/07/18) revealed, that during a [redacted] by the hospice nurse on [redacted]/18, 4 [redacted] were found on R #1's body when there should have been only [redacted]	A 032		

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A 032	Continued From page 34 B. Record review of the Record book of Prescriptions (03/25/no year) revealed, the direction for use for [redacted] C. On 09/12/18 at 11:15 am, during an interview with the Administrator, she confirmed that the hospice nurse found [redacted] on R #1 instead of [redacted] The Administrator confirmed she did not report the medication error to the Licensing Authority as required. D. On 09/12/18 at 2:24 pm, during an interview with [name of hospice director], she confirmed that [name of nurse] found [redacted] on R #1's body on 02/07/18. Findings related to R #7 & 8 E. Record review of R #7's file revealed, a note (not dated) stating that on [redacted]17 at 8:50 am, R #7[redacted] on the curb outside the facility, [redacted] There was no documentation of an internal incident report or that the [redacted] was reported to the Licensing Authority. F. Record review of R #8's progress notes (dated [redacted]/18) revealed, that [redacted] claimed that Direct Care Staff (DCS) #5 [redacted] There was no documentation of an internal incident report or that the possible [redacted] by DCS # 5 was reported to the Licensing Authority. G. Record request for the facility's internal & state incident reports, revealed there were no reports available for review.	A 032		

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A 032	Continued From page 35 H. On 09/19/18 at 2:05 pm, during an interview with the Administrator, she stated that there are no internal incident reports available for review for R #s 7 & 8, that incidents are only documented in the resident's progress notes. I. On 09/12/18 at 2:15 pm, during an interview with the Administrator, she confirmed that there were no internal or state incidents available for review. She stated that she stopped reporting incidents to the Licensing Authority years ago.	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.	A 033		

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A 033	Continued From page 36 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. 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	A 033		

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A 033	Continued From page 37 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 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;	A 033		

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A 033	Continued From page 38 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 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 D (1) (4) (7) (9) (11) (m) Based on record review, observation, and interview the facility failed to ensure: 1. A safe and sanitary environment was maintained and free of potential harm and the contracting of illnesses from bacteria/germs. 2. Telephones were located or are able to be taken by residents allowing them to have private conversations. 3. Residents personal health information was kept confidential and not discussed where others could over hear it. 4. That residents were treated with dignity and given privacy and treated the same as all residents regarding the use of the facility restroom. 5. Residents could keep possession of their clothing at all times. This deficient practice has the potential for all 7 (R #s 2, 3, 5-9) residents listed on the resident census provided by the Administrator on 09/11/18, to be at risk of:	A 033		

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A 033	Continued From page 39 1. Ingesting bacteria, a virus, and/or foreign material. 2. Having personal and private conversations overheard by staff and visitors. 3. Personal health information not being kept confidential and protected. 4. Loss of dignity and being singled out from other residents for needing assistance with toileting. 5. Residents to not have the freedom to make their own decisions about what/when to wear their own clothing. The findings are: Findings related to touching medications: A. On 09/12/18 at 7:07 am, during an observation of the medication pass for R #5, by the Administrator, she was observed taking a pill from the bottle to the cutter with her bare hands B. On 09/12/18 at 7:08 am, during an interview with the Administrator, she confirmed that she took a pill from the bottle to the cutter with her bare hands. Finding related to knives/lancets/razors/testing strips: C. On 09/18/18 at 3:07 pm, during an observation of the kitchen, 7 sharp knives were observed being stored on the side of the pantry, unsecured, and accessible to residents with [redacted] D. On 09/18/18 at 3:08 pm, during an interview	A 033		

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A 033	Continued From page 40 with Direct Care Staff (DCS) #2, she confirmed that the 7 knives were being stored on the side of the pantry unsecured and accessible to residents [redacted] E. On 09/18/18 at 3:09 pm, during an observation of a shelf between the refrigerator and pantry, a sharps container with lancets/razor inside and a red cup with used blood testing strips next to the sharps container were observed unsecured and accessible to residents with [redacted] F. On 09/18/18 at 3:10 pm, during an interview with DCS #2, she confirmed that the sharps container with lancets/razor inside and a red cup with used blood testing strips next to the sharps container were observed unsecured and accessible to residents with [redacted] Findings related to private phone conversations: G. On 09/18/18 at 3:15 pm, during an observation there were only 2 phones (fax and table) observed to be available for resident use. Both phones were located in the kitchen preventing residents from having private phone conversations. H. On 09/19/18 at 2:30 pm, during an interview with the Administrator, she confirmed that only 2 phones (fax and table) were available for resident use. Both phones were located in the kitchen preventing residents from having private phone conversations. Finding related to resident use of hallway toilet (dignity):	A 033		

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A 033	Continued From page 41 I. Record review of a Complaint Intake (dated 06/12/18) stated, R #s 8 & 9 are not allowed to use facility (hallway) restroom. They have to use the [redacted] in their rooms with no privacy from people coming in/out of their rooms. Especially, R # 9 whose room is actually the sunroom. J. On [redacted]18 at 12:35 pm, during an interview with R #9, [redacted] stated that [redacted] liked the facility, except for not being allowed to use the shared facility restroom (hallway) and being made to clean out [redacted] K. On 09/20/18 at 10:30 am, during an interview with the Administrator, she confirmed that R #s 8 & 9 were not allowed to use the facility restroom (hallway)because [redacted] L. On [redacted]18 at 3:15 pm, during an interview with R #8, [redacted] stated [redacted] was not allowed to use the facility restroom (hallway) because [redacted] M. On 09/19/18 at 3:20 pm, during interview with [anonymous], it was confirmed that R #s 8 & 9 were made to [redacted] Findings related to confidentiality: N. Record review of a Complaint Intake (dated 08/14/18) stated the facility was not abiding by the rules of HIPAA (Health Insurance Portability and Accountability Act) by discussing resident's health information in the kitchen where other	A 033		

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(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 033	Continued From page 42 residents and visitors can over hear. O. On 09/20/18 at 2:44 pm, during an interview with the Administrator, she confirmed that resident information has been discussed in the kitchen where it could be over heard by others violating the resident's rights under the rules of HIPAA. Finding related to clothing: P. Record review of a Complaint Intake (dated 06/12/18) stated, that R #8 had [redacted] taken away and hidden, because [redacted] changes too often due to being [redacted] Q. On [redacted]/18 at 10:30 am, during an observation of the closet in resident room #1, R #9's clothing was observed hanging their and not in [redacted] room. R. On 09/20/18 at 10:30 am, during an interview with the Administrator, she confirmed that R #8's clothing was taken away because [redacted] In addition, she confirmed that R #9's [redacted] away for the same reason.	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	A 034		

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A 034	Continued From page 43 facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II	A 034		

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A 034	Continued From page 44 through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases	A 034		

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A 034	Continued From page 45 involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (1) (3) (9) Based on record review, observation, and interview the facility failed to ensure that: 1. Medications were not stored in the kitchen refrigerator with resident food. 2. A separate medication refrigerator was provided by the facility to store medications that require refrigeration. 3. Expired and discontinued medications were stored securely in a locked container, pending destruction from the consultant pharmacist. 4. Containers with used needles, lancets, razors (sharps container), and blood testing strips in a plastic cup were not left on a shelf in the kitchen, and accessible to residents (some with dementia-memory loss). These deficient practices have the potential for all 7 (R #s 2, 3, 5-9) residents listed on the census, provided by the Administrator on 09/11/18 to be at risk of harm, illness or death if: 1. Food and medication become contaminated with germs and bacteria. 2. Medications are not kept in a locked	A 034		

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A 034	Continued From page 46	A 034		

separate medication refrigerator to prevent access to the medications by residents (some with dementia-memory loss), staff or visitors who are not authorized to access the medications.

3. Discontinued/expired medications are not kept in a locked container

4. Containers with used needles, lancets, razors (sharps container), and blood testing strips are accessible to residents (some with dementia-memory loss) and they cut themselves and contaminate their blood with diseases from other residents.

The findings are:

Findings related to unsecured discontinued/expired medications:

A. On 09/19/18 at 11:47 am, during an observation and interview with the Administrator of the plastic storage cart where resident files were stored, the following expired/discontinued medications were observed to not be secured in a locked container, pending destruction by the pharmacist.

1. R# 3: 1 bubble pack (dated [redacted]/18) of [redacted] ake [redacted] remaining. The Administrator confirmed that the medication had been discontinued.

2. R #8: 1 bubble pack (dated [redacted]/18) of [redacted] The Administrator confirmed that the medication had been discontinued.

3. R #8: 1 bottle (dated [redacted]/18) of [redacted] remaining. The Administrator confirmed that the

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A 034	Continued From page 47 medication was expired. B. On 09/19/18 at 12:03 pm, during an interview with the Administrator, she confirmed that the discontinued/expired medications for R #s 3 & 8 were kept in the storage cart containing the resident files and not secured in a locked container, pending destruction by the pharmacist. Findings related to sharps container: C. On 09/18/18 at 3:09 pm, during an observation a sharps container with used needles, lancets, razors (sharps container), and blood testing strips in a plastic cup were observed sitting on a shelf in the kitchen, and accessible to residents [redacted] D. On 09/18/18 at 3:10 pm, during an interview with the Administrator, she confirmed a container with used needles, lancets, razors (sharps container), and blood testing strips in a plastic cup were observed sitting on a shelf in the kitchen, and accessible to residents [redacted] Findings related to medications being stored with food: E. On 09/18/18 at 1:47 pm, during an observation of the kitchen refrigerator the following medications were observed being stored with resident food: 1. [redacted] R #8 were observed being stored with food. 2. [redacted]	A 034		

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A 034	Continued From page 48 F. On 09/18/18 at 1:52 pm, during an interview with Direct Care Staff #2, she confirmed that the following medications were being stored in the kitchen refrigerator with resident food: 1. [redacted] R #8 were observed being stored with food. 2. [redacted]	A 034		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or	A 035		

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A 035	Continued From page 49 certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the	A 035		

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A 035	Continued From page 50 resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber.	A 035		

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A 035	Continued From page 51 J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 B G (2-5) (10-12) (17-19) L	A 035		

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A 035	Continued From page 52 Class B Deficiency On 09/12/18 at 10:00 am, a Class B Deficiency was called due to none of the Direct Care Staff (DCS) who assist residents with the self-administration of their medications had certificates of completion from a state approved course. This places the 7 (R #2, 3, 5-9) current residents to be at risk of being harmed if they received medications in the wrong dose, route, wrong time, etc., because the DCS who are assisting them with the self-administration of their medications, have not been trained and have no certificates of completion to assist with the self-administration of medications. The Administrator was informed of the Class B Deficiency at this time. On 09/19/18 at 11: 47 am, a plan of removal was received and accepted. The facility contacted a company that offers a state approved course and was able to get online and have the DCS who assist residents with the self-administration of their medications take the class and obtain certificates of completion after they passed the test. Until the DCS have completed the course and received certificates, the Administrator will assist residents with medications beginning 09/12/18, through 09/14/18. The Administrator was informed at 11:50 am that the Class B Deficiency was removed. Based on record review, observation, and interview the facility failed to ensure that: 1. Old pain medication patches were removed, before new pain patches were applied to resident's bodies. 2. Medications and treatments are started, stopped, and discontinued only with an order	A 035		

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A 035	Continued From page 53 from the physician. 3. Bedrails (half & full) are only being used with physician orders and oversite. 4, The Medication Administration Record (MAR) was accurate and contained at the required information. 5. All medications are given immediately after being removed from the bottle or bubble pack (no pre-pouring). 6. The Direct Care Staff (DCS) who assist residents with the self-administration of medications have certificates of completion from a stated approved "Assisting with Medication" course. These deficient practices have the potential for 1 (R #1) former resident and all 7 (R #s 2, 3, 5-9) current residents listed on the resident census, provided by the Administrator on 09/11/18 to be at risk of harm, injury, or death if: 1. Old pain medication patches are not removed prior to new patches being applied, then resident may be overmedicated. 2. Medications are being taken or discontinued without a physician's order, monitoring, or supervision to ensure the resident is taking the correct medications. 3. Bedrails are being used without the physicians knowledge, written orders, and the resident falls or becomes entangled in, climbs over, or around the bedrails. 4. Information on the MAR is not complete, accurate, and includes all required information, then medication errors could occur. 5. The DCS mistakenly gives residents medications for another resident. 6. The DCS: a. Have not completed a state approved Assistance with Self -Administration of	A 035		

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A 035	Continued From page 54 Medications course and received a certificate of completion. b. Do not know the possible risks to the health and safety if residents are not receiving their medication correctly because the DCS assisting them have not been trained. The Findings are: Findings related to R #1: A. Record review of a Complaint Intake, dated (06/07/18) revealed, that during a [redacted] by the hospice nurse on [redacted]/18, 4 patches of [redacted] on R #1's body when there should have been only [redacted] B. Record review of the Record book of Prescriptions (03/25/no year) revealed, the direction for use for [redacted] C. On 09/12/18 at 11:15 am, during an interview with the Administrator, she confirmed that the hospice nurse found [redacted] on R #1 [redacted] The Administrator confirmed she did not report the medication error to the Licensing Authority as required. D. On 09/12/18 at 2:24 pm, during interview with (name of hospice director), she confirmed that (name of nurse) found [redacted] on R #1's body on 02/07/18. Findings related to physician orders for medications and bedrails:	A 035		

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A 035	Continued From page 55 E. On [redacted]/18 at 10:50 am, during an observation of R #3's room, [redacted] were observed in use. The observation was confirmed by the Administrator at 10:58 am. F. Record review of R #3's resident file revealed, no documentation of physician orders since 2014 and they do not match her current mediations listed on the [redacted]/18 to [redacted]/18 MAR or for the use of [redacted]. G. On [redacted]/18 at 11:10 am, during an observation of R #6's room, [redacted] were observed in use. The observation was confirmed by the Administrator at 11:16 am. H. Record review of R #6's resident file, revealed no documentation of physician orders for her medications or [redacted]. I. On [redacted]/18 at 2:50 pm, during an observation of R #8's room, [redacted] were observed in use. The observation was confirmed by the Administrator at 2:50 pm. J. On 09/19/18 at 9:30 am, during an interview with the Administrator, she stated that if there are no physician orders in the resident files, then there are no physician orders for either the medications or bedrails. She stated that most orders get called in and she takes them over the phone. The administrator confirmed she is not a nurse and did not know that only a nurse could take orders over the phone. Findings related to MARs: K. Record review of R #2's MAR dated [redacted]/18	A 035		

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A 035	Continued From page 56 to [redacted]/18 revealed, no documentation of the following: 1. Medication allergies. 2. The brand/generic name. 3. Diagnosis. 4. Start/End date. 5. Route or Method. 6. Refused/missed medications and the reason why and adverse reactions. [redacted] L. Record review of R #3's MAR dated [redacted]/18 to [redacted]/18 revealed, no documentation of the following: 1. Physician name and contact information. 2. The brand/generic name. 3. Start/End date. 4. Route or Method. 5. Refused/missed medications and the reason why and adverse reactions. 6. Reason why PRN (as needed) were given and the results; for the following medications: [redacted] M. On 09/13/18 at 2:39 pm, during an interview	A 035		

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A 035	Continued From page 57 with the Administrator, she confirmed the above listed findings for R #s 2 & 3 MARs. Findings related to pre-pouring medications: N. On 09/12/18 at 6:55 am, during an observation of the morning med-pass, the Administrator was observed pre-pouring resident medications. O. On 09/12/18 at 6:56 am, during an interview with the Administrator, she confirmed that she pre-pours the residents medications, because it gets hectic in the mornings. Findings related to DCS training: P. Record review of DCS #s 1-3 staff files revealed no documentation that they have completed and received certificates of competition from a state approved training course for Assisting with the Self Administration of medications. Q. On 09/12/18 at 10:15 am, during an interview with the Administrator, she confirmed that DCS #s 1-3 had not completed or received certificates of completion from a state approved training course for Assisting with the Self Administration of medications. Therefore, they were not qualified to assist residents with their medications.	A 035		
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 "	A 036		

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A 036	Continued From page 58 recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more 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;	A 036		

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A 036	Continued From page 59 (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the 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	A 036		

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A 036	Continued From page 60 in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by 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	A 036		

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A 036	Continued From page 61 keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees 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	A 036		

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A 036	Continued From page 62 kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than 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	A 036		

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A 036	Continued From page 63 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) (b) (d) B (1) (4) C (1) (a) (2) (c-d) (5) D (3) (5) Based on observation and interview the facility failed to ensure that: 1. Food stored in the refrigerator was sealed, dated and labeled. 2. Food was not kept beyond the expiration date, rotting and molded. 3. Medications were not stored in the same refrigerator with food. 4. The refrigerator/freezer were kept clean and sanitary. 5. The oven was kept clean and sanitary. 6. Staff were wearing hairnets or caps when handling food. 7. There was a thermometer in the freezer and/or daily temperatures recorded 8. The weekly menu was posted where residents/families/visitors are able to view it. 9. Periodic testing of the temperature in the dishwasher were taken and recorded. These deficient practices have the potential for all 7 (R #s 2, 3, 5-9) residents identified on the census list provided by the Administrator on 09/11/18, to be at risk of harm, contracting	A 036		

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A 036	Continued From page 64 foodborne illnesses, needing outside medical attention, and not being able to make food choices if: 1. Medications stored with food become cross contaminated and ineffective. 2. Food that has become contaminated with bacteria and germs is consumed because, the food has not been stored properly and in a clean and sanitary environment. 3. Food is consumed that has expired or is rotten. 4. There was no thermometer in all freezers and the daily temperatures were not being recorded to ensure food is being stored at the correct temperatures to prevent spoilage. 5. The the oven is not kept clean, free of dirt/grease buildup and it contaminates the food being cooked. 6. They are being served food contaminated with hair and bacteria. 7. They do not know what food and snacks are being served and/or not able to make food choices. 8. The dishwasher temperature is not monitored on a regular basis to ensure the dishes/dishware are getting cleaned and sanitized. The findings are: Findings related to medication stored with food: A. On 09/18/18 at 1:47 pm, during an observation of the kitchen refrigerator revealed, the following medications were being stored in the same refrigerator as food. 1. [redacted]	A 036		

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A 036	Continued From page 65 2. [redacted] B. On 09/18/18 at 1:52 pm, during an interview with Direct Care Staff (DCS) # 2, she confirmed the observation of the [redacted] being stored in the same kitchen refrigerator as food. Findings related to refrigerator/freezer: C. On 09/18/18 at 1:47 pm, during an observation of the kitchen refrigerator and freezer revealed the following: 1. Both the refrigerator and freezer were very dirty with spillage. 2. Foods expired, not labeled, sealed, or dated: a. 1-2 lb (pound) bag of broccoli expired 08/12/18. b. 1-1 lb bag of radishes not sealed, dated or labeled. c. 1-3 lb bag of mandarin oranges expired 08/23/18, not dated/sealed, or labeled when opened. d. 1-2 lb. bag of rotting limes not sealed, dated, or labeled. e. 1 Unsealed bag of 12 rotted limes. f. 1 stalk of old celery (brown). g. 1-1 lb package of hamburger meat (whitish in color) not dated or labeled. h. 1 bag of cheese (dated 09/07/18), not labeled. i. 1 bag of cheese (dated 06/27/18), not labeled. j. 2 lbs Greek yogurt, not dated. k. 1 bowl green chili, not dated, labeled, or sealed.	A 036		

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A 036	Continued From page 66 l. 1 bowl of orange jello, not dated, labeled, or sealed. m. 3 bisqueta (biscuits) (dated 09/11/18). n. 1-pkg (package) of left over bacon, not dated or labeled. o. 1-pkg of block cheddar cheese, not dated or labeled. p. 1-3lb pkg of turkey franks (expired 09/11/18), not sealed. q. 3 bags of stew meat, not dated or labeled. D. On 09/18/18 at 2:25 pm, during an interview with DCS #2, she confirmed the above listed findings in the kitchen refrigerator. E. On 09/18/18 at 2:27 pm, during an observation of the kitchen freezer the following was observed: 1. 2-lbs of turkey meat balls, used, not sealed, not dated, or labeled when opened. 2. 2 bags of beef meat balls, not dated when opened 3. 1 bag meat balls, not sealed and not dated when opened. 4. 1-5 lb package of tator tots, not sealed or dated when opened. F. On 09/18/18 at 2:35 pm, during an interview with DCS # 2, she confirmed the above listed findings in the kitchen refrigerator. Findings related to the oven: G. On 09/18/18 at 3:03 pm, during an observation of the oven, it was observed to be dirty with grease build up on the inside and outside, including the oven door.	A 036		

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A 036	Continued From page 67 H. On 09/18/18 at 3:05 pm, during an interview with DCS #2, she confirmed that the oven was very dirty on the inside and outside, including the oven door. Findings related to weekly menus: I. On 09/13/18 at 12:00 pm, during an observation, the weekly menu was observed to not be completed, include snacks, and was not posted where residents/family/visitors can view it. J. On 09/13/18 at 12:00 pm, during an interview with the Administrator, she confirmed that the weekly menu was not complete and not posted where it can be viewed by residents/staff/ visitors. Findings related to hairnets and gloves: K. On 09/13/18 at 11:04 am, DCS #3 was observed preparing resident food without a hairnet or gloves. L. On 09/13/18 at 11:05 am, during an interview with DCS #3, she confirmed that she was not wearing a hairnet or gloves while preparing resident's food. Findings related to dishwasher temperatures: M. Record request for the dishwasher temperature logs, revealed no documentation that any periodic temperatures had been taken. N. On 09/18/18 at 3:05 pm, during an interview with DCS #2, she confirmed that there was no temperature logs for the dishwasher. DCS #2 stated she did not know about/how to test the	A 036		

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A 036	Continued From page 68 dishwasher temperature or that it had to be taken. Findings related to freezer in laundry/pantry/hot water heater room: O. On 09/11/18 at 9:16 am, during an observation of the food freezer in the laundry/pantry/hot water heater room, it was observed to not have a thermometer in it and there was no daily temperature log where the DCS were recording the temperatures each day. P. On 09/11/18 at 9:25 am, during an interview with the Administrator, she confirmed that there was no thermometer in the freezer and there were no daily temperatures logged by the DCS daily.	A 036		
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and	A 037		

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A 037	Continued From page 69 layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet. B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (10)	A 037		

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A 037	Continued From page 70 Based on observation and interview the facility failed to ensure that the cleaning supplies were stored securely and not accessible to residents with Dementia (memory loss) or mental illness. This deficient practice has the potential for the 7 (R #s 2, 3, 5-9) residents identified on the census list, provided by the Administrator on 09/11/18 to be at risk of injury or illness requiring emergency medical treatment if they consume or spill the cleaning supplies on their face or body. The findings are: A. On 09/11/18 at 9:10 am, during observation of the laundry/pantry/hot water heater room the following cleaning supplies were observed being stored with food items, unsecured and accessible to residents with Dementia (memory loss) or mental illness): 1. 6-121 oz (ounce) bottles of bleach. 2. 1-1 gallon bottle of urine stain remover. 3. Multiple bottles, cans, containers of cleaning/laundry supplies were observed on the floor and shelves, unsecured, and the laundry room was observed to not have a door. B. On 9/11/18 at 9:25 am, during interview with the Administrator, she confirmed that cleaning supplies were being stored with food items, unsecured, no door, and accessible to residents with Dementia (memory loss) or mental illness.	A 037		
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 of dirt, rubbish and dust.	A 038		

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A 038	Continued From page 71 A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. 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. 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] This REQUIREMENT is not met as evidenced by: 7.8.2.38 A B C Based on observation and interview the facility failed to ensure that the interior and exterior of the facility was maintained: 1. In a safe, clean, and sanitary manner. 2. Free of insects/rodents and droppings/carcasses, safety hazards, and accumulations of dirt, dust, and rubbish. 3. So that poisonous/flammable substances were not stored in food preparation/storage areas and accessible to residents (some with dementia (memory loss) or other mental illness. These deficient practices have the potential for all 7 (R #s 2, 3, 5-9) residents listed on the	A 038		

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A 038	Continued From page 72 census, provided by the Administrator on 09/11/18, to be at risk of injury, illness, or death from: 1. The facility not being clean and sanitary, free of germs and bacteria. 2. Being bitten or contracting diseases spread by insects and rodent droppings/carcass, contamination from an unsafe and dirty environment, and if safety hazards have not been eliminated. 3. Consuming, being splashed on body and face, and/or fire if residents (some with dementia or mental illness) are able to access the poisonous/flammable substances. The findings are: Findings related to roaches/bugs: A. On 09/11/18 at 8:06 am, during an observation of resident room #1, 2 dead cockroaches and several other dead little bugs were observed and remained there for 3-days. B. On 09/11/18 at 10:32 am, during an interview and observation with the administrator, she confirmed that there were 2-dead cockroaches and other dead little bugs in resident room #1 and 1 dead cockroach in room #2. Findings related to the laundry/pantry/hot water heater room. C. On 09/11/18 at 9:10 am, during an observation of the laundry/pantry/hot water heater room: 1. The hot water heater was observed to be surrounded by the following poisonous, combustibles and flammable chemicals on the	A 038		

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A 038	Continued From page 73 floor and next to the hot water heater: a. 6-121 oz (ounce) bottles of bleach. b. 1-1 gallon bottle of urine stain remover. c. 1-1 gallon of cooking oil. 2. Multiple bottles, cans, containers of cleaning/laundry supplies, poisonous, combustibles, and flammable chemicals were observed on the floor and shelves in the laundry/pantry/hot water room with food. 3. The laundry/pantry/hot water room was observed to not have a door at the entrance of the room and accessible to residents with mental illness and dementia. D. On 9/11/18 at 9:25 am, during an interview with the Administrator, she confirmed the above findings in the laundry/pantry/hot water room. E. On 09/11/18 at 9:10 am, during an observation of the the laundry/pantry/hot water heater room trash and bottles of chemicals (name and size unknown, unable to access) were observed between the dryer, pantry shelves and wall. F. On 9/11/18 at 9:15 am, during an interview with the Administrator, she confirmed that trash and bottles of chemicals were between the dryer, pantry shelves and wall. G. On 09/11/18 at 9:50 am, during an observation of the closet in resident room #1, 7-15 oz cans of flammable gel cleaner were observed being stored on the closet shelf. The closet did not have a door, making the cleaner accessible to residents with mental illness and dementia.	A 038		

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A 038	Continued From page 74 H. On 09/11/18 at 9:58 am, during an interview with the Administrator, she confirmed that 7-15 oz cans of flammable gel cleaner were being stored on the closet shelf in resident room #1 and that the closet did not have a door, making the cleaner accessible to residents with mental illness and dementia. Findings related to the hallway bathroom: I. On 09/11/18 at 10:00 am, during an observation of the hallway bathroom, the following chemicals and cleaning supplies were observed on the floor under the bathroom sink, unsecured and accessible to residents with mental illness and dementia: 1. 1-48 oz bottle of pine cleaner. 2. 1-100 oz bottle of pine cleaner. 3. 1-121 oz bottle of bleach. 4. 1-bottle (ounces unknown) of liquid air freshener. J. On 09/11/18 at 10:00 am, during an observation of the wire shelving in the hallway bathroom, the following spray bottles filled with bleach/pine cleaner and 1-32 oz bottle of disinfectant spray cleaner were observed hanging on the shelf unsecured and accessible to residents with mental illness and dementia. K. On 09/11/18 at 10:06 am, during an interview with the Administrator, she confirmed that above listed cleaning supplies/chemicals were being stored in the hallway bathroom, unsecured, and accessible to residents with mental illness and dementia. Findings related to house cleaning:	A 038		

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A 038	Continued From page 75 L. On 09/11/18 at 11:00 am, during an observation of the sunroom, the fan was observed to be covered with dust. M. On 09/11/18 at 11:16 am, during an interview the Administrator confirmed the above finding. N. On 09/12/18 at 6:57 am, during an observation of the kitchen, the air vent was observed to be very dirty. O. On 09/12/18 at 6:58 am, during an interview the Administrator confirmed the above finding. P. On 09/12/18 at 7:05 am, during an observation of the kitchen window air conditioner unit, it was observed to be dirty and rusty. Q. On 09/12/18 at 7:06 am, during an interview the Administrator confirmed the above finding. R. On 09/11/18 at 9:10 am, during an observation of the laundry/pantry/hot water heater room, trash, dryer fuzz and a plastic bottle of unknown chemical/cleaner (unreachable) was observed between the dryer and food rack. S. On 09/11/18 at 9:15 am, during an interview the Administrator confirmed the above finding. T. On 09/11/18 at 11:10 am, during an observation of the furnace room, in resident room #7 an unknown substance, bugs, and/or dirt/dust was observed inside the open hole in wall at the side of the furnace. U. On 09/11/18 at 11:10 am, during an interview the Administrator confirmed the above finding.	A 038		

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A 038	Continued From page 76 Findings related to chemicals/combustibles on back porch and walkway: V. On 09/18/18 at 1:35 pm, during an observation, the following chemicals/combustibles were observed on the back porch/walkway accessible to residents, with dementia and mental illness: 1. 1-17 oz can of orange paint primer. 2. 1-128 oz bottle of liquid weed killer/edger. 3. 1-1 gallon of windshield wiper fluid. W. On 09/18/18 at 1:40 pm, during an interview with the Administrator, she confirmed the observation of the above listed chemicals/combustibles on the back porch/walkway and accessible to resident with dementia and mental illness. Findings related to cupboard under the kitchen sink: X. On 09/18/18 at 2:45 pm, the following cleaning/chemicals/combustibles supplies were observed under the kitchen sink, unsecured and accessible to residents: 1. 1-75 oz box of dishwasher powder. 2. 1 box of 10 SOS pads. 3. 1-25.2 oz can of comet. 4. 1-48 oz of pine cleaner. 5. 1-7.5 oz bottle of hand soap. 6. 1-56 oz bottle of multipurpose cleaner. 7. 1-15 oz can of cleaner. 8. 2-121 oz bottles of bleach. 9. 1-32 oz bottle of deodorizer 10. 1-32 oz bottle of carpet cleaner. 11. 1-32 oz bottle of multi task degreaser/window cleaner. 12. 1-16 oz bottle of odor eliminator.	A 038		

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A 038	Continued From page 77 13. 1-32 oz bottle of bug spray. 14. 1-56 oz bottle of hand soap. 15. 1-2 qt bottle of drain cleaner. 16. 1-32 oz bottle of mop and glow. 17. 1-26 oz bottle of Windex. 18. 1-emergency candle. 19. 1-50 oz bottle of carpet shampoo. 20. 1-32 oz bottle of wood oil cleaner. 21. 2-16 oz bottles of lemon oil. 22. 2-8 oz bottles of dark wood oil cleaner. Y. On 09/18/18 at 2:56 pm, during an interview with DCS #2, she confirmed the observation of the cleaning/chemical/combustible supplies being stored under the sink, unsecured and accessible to residents with dementia and mental illness.	A 038		
A 041	7 NMAC 8.2.41 Building Construction BUILDING CONSTRUCTION: All building construction shall be based upon the facility occupancy in accordance with the state building code and fire codes, pursuant to 14.7 NMAC. A. New facilities. All new facilities, relocated into existing building(s) or remodeled facilities shall conform to the current edition of the state building code, accessibility code, mechanical code, plumbing code, fire code and the electrical code. (1) With regard to building height, allowable area or construction type, the state building code shall prevail. (2) Minimum construction requirements shall comply with all applicable state building codes. (3) A facility may share a building with another health care facility licensed by the department or other suitable facility with prior approval from the licensing authority. (4) Where there are conflicts between the	A 041		

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A 041	Continued From page 78 requirements in the codes and the provisions of this rule, the most restrictive condition shall apply. B. Access for persons with disabilities. Facilities with four (4) or more residents shall provide accessibility to residents with disabilities in accordance with the state building code and the American Disabilities Act. Areas of specific concern are as follows: (1) the main entry into the facility and all required exits shall provide access to persons with disabilities; (2) the building shall allow access to persons with disabilities to all common areas; (3) at least one bedroom, for every eight (8) residents, shall have a door clearance of thirty-six (36) inches for access by persons with disabilities; (4) at least one toilet and bathing facility, for every eight (8) residents, shall have a minimum door clearance of thirty-six (36) inches for access by persons with disabilities; this toilet and bathing room shall provide a minimum sixty (60) inch diameter clear space to accommodate the turning radius of a wheelchair; (5) when ramps are used, each ramp shall have a minimum slope of twelve (12) inches horizontal run for each one (1) inch of vertical rise; ramps exceeding a six (6) inch rise shall be provided with handrails on both sides of the ramp; (6) landings at doorways shall have a level area, at a minimum of five (5) feet by five (5) feet, to provide clear space for wheelchair maneuvering; (7) parking spaces shall provide access aisles with a minimum width of sixty (60) inches and ninety-six (96) inches for van parking; a minimum of one (1) van-accessible parking space with a minimum width of ninety-six (96) inches shall be provided;	A 041		

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A 041	Continued From page 79 (8) an accessible route for persons with disabilities from the parking area to the main entrance(s) shall be provided; and (9) changes in elevation of one half inch (1/2 inch) or greater shall be sloped to a minimum of twelve (12) inches horizontal run for each one (1) inch of vertical rise. C. Construction drawings. Prior to commencement of all new construction, remodeling, relocations, additions or renovations to existing buildings; the facility shall submit preliminary plans and final construction drawings with specifications to the licensing authority for review and approval. (1) Building plans and specifications shall be submitted and approved by the department when: (a) construction for a new facility is proposed; (b) a building that has not previously licensed as a facility is proposed as a location for a facility; (c) any renovation that increases the number of beds is proposed; (d) any addition to an existing structure is proposed; or (e) any renovation to the existing structure is proposed, regardless of the size of the facility. (2) The codes that are in effect at the time of the submittal of building plans shall be the codes used through the end of the project. (3) Drawings and specifications shall be prepared for the architectural, structural, mechanical and electrical branches of work for each construction project and shall include the following: (a) the site plan(s) showing property lines, finish grade, location of existing and proposed structures, roadways, walks, utilities and parking areas; (b) the floor plan(s) showing scale drawings of	A 041		

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A 041	Continued From page 80 typical and special rooms, indicating all fixed and movable equipment and major items of furniture; (c) the separate life safety plans showing the fire and smoke compartment(s), all means of egress and exit markings, exits and travel distances, dimensions of compartments and calculation and tabulation of exit units, all fire and smoke walls shall be graphically coded; (d) the exterior elevation of each facade; (e) the typical sections throughout the building; (f) the schedule of finishes; (g) the schedule of doors and windows; (h) the roof plans; and (i) the building code analysis. (4) For facilities with more than fifteen (15) residents: architectural drawings shall be stamped, signed and dated by a licensed architect registered in New Mexico. In addition to items listed in section (3) above, the drawings shall include the following: (a) the building code analysis; and (b) when an elevator is required, the details and dimensions of the elevator. (5) Structural drawings shall include the following: (a) a certification that all structural design and work are in compliance with all applicable local codes; (b) the plans of foundations, floors, roofs and intermediate levels that show a complete design with sizes, sections and the relative location of the various members; and (c) the schedules of beams, girders and columns. (6) Mechanical drawings shall include the following: (a) a certification that all mechanical work and equipment are in compliance with all applicable local codes and laws and that all materials are listed by recognized testing laboratories;	A 041		

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A 041	Continued From page 81 (b) the water supply, sewage and heating, ventilation and air conditioning piping systems; (c) the heating, ventilating, HVAC piping and air conditioning systems with all related piping and auxiliaries, if any, to provide a satisfactory installation; (d) the water supply, sewage and drainage with all lines, risers, catch-basins, manholes and cleanouts clearly indicated as to location, size, capacities and location and dimensions of septic tank and disposal field; (e) the sprinkler head layout; and (f) the graphic coding (with a legend) to show supply, return and exhaust systems. (7) Electrical drawings shall include the following: (a) a certification that all electrical work and equipment are in compliance with all applicable local codes and laws and that all materials are currently listed by recognized testing laboratories; (b) all electrical wiring, outlets, riser diagrams, switches, special electrical connections, electrical service entrance with service switches, service feeders and characteristics of the light and power current and transformers when located within the building; (c) a fixture legend; and (d) a graphic coding (with a legend) to show all items on emergency power. (8) Include additional information as needed and requested by the licensing authority. (9) Final working drawings and specifications shall be accurately dimensioned and include all necessary explanatory notes, schedules, legends and have all rooms labeled. The working drawings and specifications shall be complete and adequate for contract purposes. (10) One set of final plans shall be submitted to the licensing authority for review and approval	A 041		

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A 041	Continued From page 82 prior to the commencing of construction. All construction shall be executed in accordance with the approved final plans and specifications. (11) Review and approval of building plans by the licensing authority does not eliminate responsibility of the applicant to comply with all applicable laws, rules and ordinances. (12) The final approval of building plans and specifications shall be acknowledged in writing by the licensing authority. (13) The approved building plans shall be kept at the facility and readily available at all times. D. Fire resistance. Required building construction and fire resistance shall be in accordance with the state building code and the fire code. Facilities with nine (9) or more residents shall be protected throughout by an approved automatic fire protection (sprinkler) system. E. Prohibition of mobile homes. For facilities with four (4) or more residents, trailers and mobile homes shall not be used. F. Construction. Construction shall commence within one hundred eighty (180) calendar days of the date of receipt of approval (unless a written extension is requested by the facility and approved by department). This approval shall in no way permit or authorize any omission or deviation from the requirements of any restrictions, laws, ordinances, codes or standards of any regulatory agency. [7.8.2.41 NMAC - Rp, 7.8.2.41 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.41 B (7) Based on observation and interview the facility	A 041		

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A 041	Continued From page 83 failed to ensure there was at least 1 identified (handicap parking sign) van accessible handicap parking space for persons with disabilities. If there is no identified van accessible parking space, then the 7 (R#s 2, 3, 5-9) residents/family/visitors with disabilities may not be able to load/unload from the van safely. The findings are: A. On 09/20/18 at 5:00 pm, during an observation of the front and side parking areas, there was no identified van accessible parking place observed for persons with disabilities. B. On 09/20/18 at 5:00 pm, during an interview with the Administrator, she confirmed that there was no identified van accessible parking place for persons with disabilities.	A 041		
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]	A 042		

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A 042	Continued From page 84 This REQUIREMENT is not met as evidenced by: 7.8.2.42 A B Based on observation and interview the facility failed to ensure that the: 1. Building and grounds were free of drywall penetrations, exposed wiring, and foundation cracks that create a tripping hazard. 2. Walkway and driveway were in good repair and free of tripping hazards. These deficient practices have the potential for all 7 (R #s 2, 3, 5-9) residents identified on the census provided by the Administrator on 09/11/18, to be at risk of harm, illness, injury, or death if: 1. They were to trip or fall on the cracks in the resident room floors. 2. Suffer electrical shock/electrocution, or be unaware that a fire has occurred, if the exposed wires either causes a fire and/or the smoke detector does not sound an alarm. 3. Suffer burns and smoke inhalation (smoke in lungs), if a fire were to occur and the smoke/flames were able to spread faster due to the holes (drywall penetrations) in the walls and ceilings. 4. They were exposed/bitten by disease carrying insects/rodents that entered from the multiple holes in the floors and ceilings. 5. They were to trip and fall on the cracks, loose gravel, and uneven gravel on the driveway and walkway. The findings are: Findings related to foundation cracks in resident	A 042		

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A 042	Continued From page 85 rooms: A. On 09/11/18 at 10:27 am, during an observation of resident room #s 1 & 2 large cracks from foundation shifts were observed in the floors. B. On 09/11/18 at 10:32 am, during an interview with the Administrator, she confirmed that there were large cracks from foundation shifts in the floors of resident room #s 1 & 2. Findings related to exposed wires: C. On 09/11/18 at 8:25 am, during an observation of the sunroom, being used as a resident room, the smoke detector (unknown if working) was observed hanging down from the ceiling with exposed wires. D. On 09/11/18 at 11:16 am, during an interview with the Administrator, she confirmed that the smoke detector was hanging down from the ceiling with exposed wires. Findings related to drywall penetrations: E. On 09/11/18 at 8:25 am, during an observation, the smoke detector in the sunroom, being used as a resident's room, was observed to be hanging down from the ceiling with exposed wires and creating a drywall penetration. F. On 09/11/18 at 11:16 am, during an interview it was confirmed by the Administrator that the sunroom was hanging down from the ceiling with exposed wires and creating a drywall penetration.	A 042		

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A 042	Continued From page 86 G. On 09/11/18 at 10:00 am, during an observation of the facility bathroom, a large section of the wall was observed to be missing behind the toilet, creating a drywall penetration. H. On 09/11/18 at 10:06 am, during an interview it was confirmed by the Administrator that a section of wall in the facility bathroom was missing causing a drywall penetration. I. On 09/11/18 at 10:40 am, during an observation of resident room #5, the cable outlet was observed to be inside the wall creating a drywall penetration. J. On 09/11/18 at 10:45 am, during an interview it was confirmed by the Administrator that the cable outlet was creating a drywall penetration. K. On 09/11/18 at 11:10 am, during an observation of the furnace (inside wall) in resident room #7, multiple drywall penetrations were observed in wall and ceiling, and to the side of the furnace. Findings related to the driveway/walkways: L. On 09/11/18 at 8:10 am, during an observation of the side driveway and alkways to the front door were observed to have multiple cracks, rough spots, loose/missing cement and gravel, creating a tripping hazard. M. On 09/20/18 at 5:00 pm, during an observation and interview with the Administrator walkways and driveway were observed to have multiple cracks, rough spots, loose/missing cement and gravel, creating a tripping hazard.	A 042		

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A 042	Continued From page 87 The Administrator confirmed the observation.	A 042		
A 047	7 NMAC 8.2.47 Lighting and Lighting Fixtures LIGHTING AND LIGHTING FIXTURES: A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area clearly visible. B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting. C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the residents, with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering. E. Facilities with four (4) or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service. F. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7.8.2.47 NMAC - Rp, 7.8.2.48 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.47 D E Based on observation and interview the facility failed to ensure that:	A 047		

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A 047	Continued From page 88 1. All lighting fixtures have protective covers. 2. The bulbs in all emergency lighting are in working order. This deficient practice has the potential for all 7 (R #s 2, 3, 5-9) residents listed on the census, provided by the Administrator on 09/11/18 to be at risk of harm, injury, and/or death if: 1. The light bulbs fall or break and there are no protective covers on the lighting fixtures, protecting residents from broken glass or falling bulbs. 2. The emergency lights do not work and residents can't see how to reach the exits, if a fire or other emergency requiring evacuation were to occur. The findings are: A. On 09/11/18 at 9:20 am, during an observation of: 1. The laundry/pantry/hot water heater room the florescent lights were observed to not have a cover. 2. The light in the hallway to the Administrator's office was observed to not have a cover. B. On 09/11/18 at 9:58 am, during an interview with the Administrator, she confirmed that: 1. The laundry/pantry/hot water heater room the florescent lights were observed to not have a cover. 2. The light in the hallway to the Administrator's office was observed to not have a cover. C. On 09/11/18 at 10:00 am, during an observation of the hallway bathroom a heating lamp with 2 bulbs was observed to not have a cover.	A 047		

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A 047	Continued From page 89 D. On 09/11/18 at 10:06 am, during an interview with the Administrator, she confirmed that the heating lamp with 2 bulbs did not have a cover. E. On 09/11/18 at 10:50 am, during an observation of resident room #6, the florescent lights were observed to not have a protective cover. F. On 09/11/18 at 10:58 am, during an interview with the Administrator she confirmed that the florescent lights in resident room #6, did not have a protective cover. G. On 09/13/18 at 3:08 pm, during an observation of the emergency light outside the facility bathroom, 2-bulbs were observed to be not working. H. On 09/20/18 at 4:00 pm, during an interview with Direct Care Staff #4, she confirmed that the 2-bulbs in the emergency light outside the facility bathroom were not working.	A 047		
A 048	7 NMAC 8.2.48 Electrical System ELECTRICAL SYSTEM: A. All fuse and breaker boxes shall be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility shall know the location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances shall be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear. (2) Extension cords shall not be used. The use of	A 048		

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A 048	Continued From page 90 a multi-socket united laboratories approved (U/L APPROVED) surge protector with integrated circuit breaker no greater than six (6) feet in length is permitted for the intended purpose and not as an extension cord. [7.8.2.48 NMAC - Rp, 7.8.2.49 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.48 GFCI NFPA 70 National Electric Code 210.8 Ground Fault Circuit Interrupter Protection for Personnel 210.8 (B) Other than dwelling units. All 125 volt, single phase, 15 and 20 ampere receptacles installed in the locations specified in 210.8 (B)(1) through (8) shall have ground fault circuit interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception 1: to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow melting, de-icing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22 as applicable. Exception 2: to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)	A 048		

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A 048	Continued From page 91 (2)shall be permitted for only those receptacles outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 6 ft. of the outside edge of the sink. Exception 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. 314.25: Covers and Canopies. In completed installations, each box shall have a cover, faceplate, lampholder, or luminaire canopy, except where the installation complies with 410.24(B) 406.5(F): Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. Based on observation and interview, the facility failed to ensure electrical outlets within 6 feet of a water source are fitted with Ground Fault Circuit	A 048		

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A 048	Continued From page 92 Interrupter (GFCI) sockets. This deficient practice has the potential for all 7 (R #s 2, 3, 5-9)residents identified on the census, provided by the Administrator on 09/11/18, to be at risk of harm or death from electric shock or electrocution. The findings are: A. On 09/11/18 at 9:10 am, during an observation of the laundry/pantry/hot water room with the Administrator the following was observed: 1. Electrical outlet the washer/ice maker (within 6 feet of a water source) was observed to not be a GFCI outlet. 2. An electrical circuit breaker box was blocked by food stored on the top pantry shelf. B. On 09/11/18 at 9:15 am, during an interview with the Administrator, she confirmed that: 1. Electrical outlet the washer/ice maker (within 6 feet of a water source) was observed to not be a GFCI outlet. 2. An electrical circuit breaker box was blocked by food stored on the top pantry shelf. C. On 09/11/18 at 10:00 am, during an observation of the hallway bathroom, the electrical outlet next to the sink was observed to not be a GFCI outlet. D. On 09/11/18 at 10:06 am, during an interview the Administrator confirmed there was not a GFCI outlet next to the sink in the hallway bathroom. E. On 09/11/18 at 10:40 am, during an observation of the electrical outlets next to the sink on both sides of the toilet were observed to not be GFCI outlets.	A 048		

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A 048	Continued From page 93 F. On 09/11/18 at 10:45 am, during an interview the Administrator confirmed that the outlets on both sides of the toilet were not GFCI outlets. G. On 09/11/18 at 11:10 am, during an observation of the bathroom/laundry room in resident room #7, the electrical outlet for the washer was observed to not be a GFCI outlet. H. On 09/11/18 at 11:16 am, during an interview the administrator confirmed that the electrical outlet next to the washer was not a GFCI outlet. I. On 09/18/18 at 3:03 pm, during an observation of the the kitchen outlets near and under the sick, the outlets were observed to not be GFCI outlets. J. On 09/18/18 at 3:05 pm, during an interview with Direct Care Staff #2, she confirmed that the kitchen outlets near and under the sick, were not GFCI outlets.	A 048		
A 049	7 NMAC 8.2.49 Doors DOORS: A. No door in any means of egress shall be locked against egress when the building is occupied. (1) Exit doors may be provided with a night latch, dead bolt, or security chain, provided these devices are operable from the inside, by any occupant, without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed forty-eight (48) inches above the finished floor. (2) If locks are not readily operable by all occupants within the building, the locks must: 1) unlock upon activation of the fire detection or	A 049		

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A 049	Continued From page 94 sprinkler system and 2) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written approval from the building, fire and licensing authorities having jurisdiction. B. All exit doors shall have a minimum width of thirty-six (36) inches. (1) Facilities with a capacity of ten (10) or more residents shall have exit doors leading to the outside of the facility that open outward. (2) Facilities with a capacity of fifty (50) or more residents must provide panic hardware at the exit doors. (3) No door or path of travel to a means of egress shall be less than twenty-eight (28) inches wide. C. All resident sleeping room doors must be at least one and three-quarters (1 3/4) inch solid core construction. D. Bathroom doors may be twenty-four (24) inches wide. Facilities with four (4) or more residents shall have at least one bathroom for every eight (8) residents with a door clearance of thirty-six (36) inches for access by persons with disabilities. E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside. F. All doors shall readily open from the inside. G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms. [7.8.2.49 NMAC - Rp, 7.8.2.50 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.49 A (1) (2) F G Class B Deficiency	A 049		

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A 049	Continued From page 95 On 09/12/18 at 10:00 am, a Class B Deficiency was called due to: 1. The front and back exit doors having multiple types of locks (turn knob, key locks, and slide bar locks) in use, that could not be unlocked by all residents. 2. The resident room doors had turn knob locks that did not release with 1 motion. Placing all residents and occupants of the building at risk of harm, injury, and/or death if a fire or other emergency requiring evacuation were to occur and residents/occupants are unable to exit the facility if: 1. They become trapped behind locked doors that require a key, could not be opened by all occupants, did not automatically release upon activation of the fire detection, and/or during loss of power. 2. Resident sleeping room doors do not unlock with 1 motion, preventing resident's from exiting their rooms in the event of a fire, loss of power, or an emergency that requires evacuation. The Administrator was informed of the Class B Deficiency at this time. On 09/19/18 at 11:47 am, A Plan of Removal was received, stating that the locks on the front and back door will be changed so residents and all occupants can exit the door with 1 motion. The Administrator was informed that the Plan of Removal was received and accepted at this time. Based on observation and interview, the facility failed to ensure that all: 1. Exit door locks (key lock deadbolt/slide bolt/turn knob) could be operated by all	A 049		

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A 049	Continued From page 96 residents/occupants of the facility or unlocked upon activation of the fire detection or during loss or power without the use of a key. 2. Resident sleeping room doors can be readily opened from the inside. 3. Bathrooms and restrooms have doors. These deficient practices have the potential for all 7 (R #s 2, 3, 5-9) residents listed on the resident census, provided by the Administrator on 09/11/18 to be at risk of not having privacy in the restroom/bathroom or harm, injury, or death if: 1. A fire or other emergency requiring evacuation were to occur and residents/occupants are unable to exit the facility, if they were trapped behind locked doors that require a key, could not be opened by all occupants, did not automatically release upon activation of the fire detection, and/or during loss or power. 2. The resident sleeping room doors are locked and residents are not able to readily open it in the event of a fire, loss of power, or an emergency that requires evacuation. 3. The resident restrooms/bathrooms do not have doors to ensure privacy when toileting or bathing. The findings are: Findings for exit doors: A. On 09/11/18 at 8:15 am, during an observation of the front exit door, it was observed to have both a turn knob lock and a key lock deadbolt, that could not be opened by all residents/occupants of the building and required the use of a key.	A 049		

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A 049	Continued From page 97 B. On 09/11/18 at 8:25 am, during an interview and observation, the back exit door was observed to be locked, with a turn knob lock that did not open with one motion, a sliding bar lock, and a key lock deadbolt, that was not able to be readily opened by all residents/occupants of the facility, preventing them from exiting through the door and blocking the path of egress. The Administrator stated that the exit doors are kept locked because several of residents have dementia (A group of thinking and social symptoms that interferes with daily functioning) and would wander out of the facility if the doors are not kept locked. C. On 9/11/18 at 11:16 am, during an interview with the Administrator, she confirmed that the back exit door had 3 locking mechanisms, (2 in the locked position) which were locked and not able to be readily opened by all residents/occupants of the facility, blocking the path of egress. D. On 09/18/18 at 1:23 pm, during an observation of the front and back doors, it was observed that they both still had key locks and dead bolts on them that could not be opened by all occupants in the facility. E. On 09/19/18 at 8:25 am, during an observation, the front door was observed to still have a key lock dead bolt on it. F. On 09/19/18 at 9:21 am, during an interview with the Administrator, she confirmed that the front/back door locks still need to be changed. The observation was confirmed by the Administrator at 9:25 am.	A 049		

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	2043	A. BUILDING: _____ B. WING _____	09/14/2018

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A 049	Continued From page 98 Findings related to resident room doors: G. On 09/11/18 at 8:59 am, during an observation and interview all resident room doors were observed to have turn knob locks that if locked, could not be opened with 1 motion. The observation was confirmed by the Administrator. H. On 09/11/18 at 10:40 am, during an observation of resident room #5, the doorknob on the room door was observed to be on backwards (with lock on the outside of the room), where resident could be locked in the room. I. On 09/11/18 at 10:45 am, during an interview with the Administrator, she confirmed that the doorknob on resident room #5's door was on backwards (with lock on the outside of the room), where resident could be locked in the room. J. On 09/11/18 at 11:10 am, during an observation of resident room #7, both the door to the sunroom and to the back yard were observed to have turn knob locks that did not open with 1 motion. K. On 09/11/18 at 11:16 am, during an interview the Administrator confirmed both the door to the sunroom and to the back yard were observed to have turn knob locks that did not open with 1 motion. Findings related Bathroom doors: L. On 09/11/18 at 8:20 am, during an observation, the facility bathroom was observed to only have a curtain as a door. L. On 09/11/18 at 10:50 am, during an	A 049		

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A 049	Continued From page 99 observation for the shared bathroom for resident room numbers 5 & 6, no bathroom doors were observed in either room. M. On 09/20/18 at 3:41 pm, during an interview with the Administrator, she confirmed that the facility bathroom and the bathrooms in resident rooms 5 & 6, did not have doors on them.	A 049		
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	A 050		

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A 050	Continued From page 100 gate site. [7.8.2.50 NMAC - Rp, 7.8.2.51 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.50 E Based on observation and interview the facility failed to ensure that exit paths and means of exit did pass through a resident's room. This deficient practice has the potential for all residents (R #s 2, 3, 5-9) listed on the resident census provided by the Administrator on 09/11/18 and all occupants to be a risk of harm, injury, and/or death, if they are not able to exit the building though a primary exit route, if a fire or other emergency requiring evacuation were to occur. The findings are: A. On 09/11/18 at 8:25 am, during an observation, the sunroom was observed being used as a resident's room (not approved by the Licensing Authority), causing residents, staff, and all occupants of the facility to have to go through a resident's sleeping room to evacuate through the back exit door. B. On 09/11/18 at 8:59 am, during an interview with the Administrator, she confirmed that the sunroom was being used as a resident's room, causing residents, staff, and all occupants of the facility to have to go through a resident's room to evacuate through the back exit door.	A 050		
A 051	7 NMAC 8.2.51 Separation of Sleeping Rooms	A 051		

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A 051	Continued From page 101 SEPARATION OF SLEEPING ROOMS: A. All sleeping rooms shall be separated from escape route corridors by walls and doors that are smoke resistant. There shall be no passages, louvers, or transfer grills penetrating the wall to other spaces in the building. B. All sleeping rooms shall be provided latches suitable for keeping the doors closed. C. Every sleeping room shall have access to a primary means of escape that provides a path to the exterior, without exposure to unprotected vertical openings. Where sleeping rooms are above or below the level of exit discharge, the primary means of escape shall be: (1) an enclosed interior stair; or (2) an exterior stair; or (3) a horizontal exit; or (4) an existing approved fire escape stair. D. Every sleeping room shall provide a secondary means of escape which may be any one of the following: (1) a door leading directly to the outside, at or to grade level; (2) a door, stairway, passage or hall remote from the primary escape and to the exterior; or (3) an outside window or door, operable without tools from the inside with a minimum clear opening measured twenty (20) inches wide, measured twenty-four (24) inches high; the distance of the bottom of the opening from the floor is a maximum of forty-four (44) inches; this means of escape is acceptable if the bottom of the window is no more than twenty (20) feet above grade or is accessible by fire department rescue apparatus, approved by the authority having jurisdiction, or it opens onto an exterior balcony; and (4) bars, grills, grates or similar devices that are installed on emergency escape or rescue	A 051		

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A 051	Continued From page 102 windows or doors shall be equipped with release mechanisms which are operable from the inside without the use of a key or special knowledge or effort. E. Stairways and other vertical openings between floors shall be enclosed with construction to provide a smoke and fire resistance rating of not less than twenty (20) minutes. Open stairways between floors shall not be permitted. [7.8.2.51 NMAC - Rp, 7.8.2.52 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.51 A C Class B Deficiency On 09/12/18 at 10:00 am, a Class B deficiency was called due to the sunroom (non-authorized room) being used as a resident sleeping room, preventing direct access to the back exit door (a primary exit route) and resident room #7. The Administrator was inform at this time. On 09/19/18 at 11:47 am, the following Plan of Removal was received and accepted. 1. The Case Coordinator for the resident residing in the sunroom will be notified of a possible need for discharge. 2. The facility is applying for a variance to make resident room #2 a semi-private room. 3. At the end of the survey the Administrator informed the surveyors that the resident will be moved into resident room #1 (empty) instead of her moving a new resident in to the room. The Administrator was informed that the Class B	A 051		

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A 051	Continued From page 103 Deficiency was removed at this time. Based on observation and interview the facility failed to ensure that: 1. Only approved/designated rooms shall be used as a resident sleeping area. 2. Resident rooms were separate from evacuation routes. 3. Residents have access to a primary means of escape without having to pass through a sleeping room to exit the building. This deficient practice has the potential for all residents (R #s 2, 3, 5-9) listed on the resident census provided by the Administrator on 09/11/18 and all occupants to be a risk of harm, injury, and/or death, if they are not able to exit the building though a primary exit route if a fire or other emergency requiring evacuation were to occur. The findings are: A. On 09/11/18 at 8:25 am, during an observation of the sunroom, it was observed being used as a resident room, preventing a direct path to the back-exit door and direct access to resident room #7. B. On 09/11/18 at 11:16 am, during an interview the Administrator confirmed that the sunroom, was being used as a resident room, preventing a direct path to the back-exit door and direct access to resident room #7. C. On 09/11/18 at 2:27 pm, during an interview with [name of Life Safety Code Surveyor], he stated that the sunroom was not an approved sleeping room and cannot be used as a resident's room because it prevents a direct	A 051		

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A 051	Continued From page 104 access to the back exit door and to resident room #7.	A 051		
A 060	7 NMAC 8.2.60 Fire Clearence and Inspections FIRE CLEARANCE AND INSPECTIONS: A. Written documentation of a facility's compliance with applicable fire prevention codes shall be obtained from the state fire marshal ' s office or the fire prevention authority with jurisdiction and shall be submitted to the licensing authority prior to the issuance of an initial license. B. The facility shall request an annual fire inspection from the local fire prevention authorities. If the policy of the local fire department does not provide an annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility. [7.8.2.60 NMAC - Rp, 7.8.2.59 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.60 B Based on record review and interview, the facility failed to ensure that an annual fire inspection by the Local Fire Authority (having jurisdiction) had been conducted. This deficient practice has the potential for all 7 (R #s 2, 3, 5-9) residents identified on the resident census provided by the Administrator on 09/11/18, to be at risk of injury or death if a fire occurs. The findings are:	A 060		

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A 060	Continued From page 105 A. Record request for the annual fire inspection by the Local Fire Authority revealed, no documentation of the last fire inspection completed by the Local Fire Authority was available for review. B. On 09/20/18 at 5:00 pm, during an interview with the Administrator, she confirmed that there is no documentation of the last fire inspection by the local fire authority available for review.	A 060		
A 061	7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: 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.	A 061		

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A 061	Continued From page 106 (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 A B (2) Based on observation and interview the facility failed to ensure that: 1. The manual fire alarm pull station was accessible for use in case of fire. 2. Smoke detectors in resident rooms were securely attached to the ceiling (unknown if working). This deficient practice has the potential for all 7 (R #s 2, 3, 5-9) residents identified on the census provided by the Administrator on 09/11/18 and all occupants of the building to be at risk of harm, injury, or death if a fire were to occur. The findings are: Findings related to fire alarm pull station: A. On 09/11/18 at 9:30 am, during an observation the fire alarm pull station at the front door, was observed to be covered with tape, so that it could not be pulled. B. On 09/11/18 at 9:58 am, during an interview with the Administrator, she confirmed that the fire alarm pull station was covered with tape, so that it could not be pulled.	A 061		

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A 061	Continued From page 107 Findings related to smoke alarms: C. On 09/11/18 at 8:25 am, during an observation of the sunroom, being used as a resident room, the smoke detector (unknown if working) was observed hanging down from the ceiling with exposed wires, creating a drywall penetration. D. On 09/11/18 at 11:16 am, during an interview with the Administrator, she confirmed that the smoke detector was hanging down from the ceiling with exposed wires, creating a drywall penetration.	A 061		
A 064	7 NMAC 8.2.64 Fire Safety Equivalency System Rating FIRE SAFETY EQUIVALENCY SYSTEM RATING: In facilities without a sprinkler system; the fire safety equivalency system shall be conducted at least annually. The facility shall maintain an evacuation rating score of prompt when a fire safety equivalency system is required. [7.8.2.64 NMAC - Rp, 7.8.2.19 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.64 Class B Deficiency On 09/12/18 at 10:00 am, a Class B Deficiency was called due to the facility not being in compliance with Fire Safety Evacuation Score (FSES) requirement of maintaining a score of	A 064		

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A 064	Continued From page 108 "prompt". The facility Administrator was aware of the requirement (when there is no sprinkler system), but had not been completing the FSES evaluation form with each resident admission, discharge, or change in condition. When the score was calculated on 09/11/18 based on the resident evaluations completed by the Administrator, the results were a score of 4.24 (slow). The results indicated that the facility did not have enough staff on duty to safely evacuate the residents if a fire or other emergency that requires evacuation. The Administrator was informed of the Class B deficiency at this time. On 09/11/18 at 3:30 pm, during an interview with the Administrator, she confirmed that based on her evaluation of the residents the evacuation rating score was 4.24 which would require 3 Direct Care Staff (DCS) on duty, awake, and immediately available 24/7 to reach a "prompt" rating score. The Administrator requested that a DCS complete the resident evacuation forms, since they know the residents better. On 09/14/18 a new FSES score was calculated based on the resident evaluations completed by the by a Direct Care Staff (DCS) and reviewed/changes made by the Administrator, the results were a rating score of 3.04 (slow). The Administrator will hire more DCS staff to ensure 2 DCS are on duty, awake, and immediately available 24/7 and a caregiver (Administrator lives on the property) nearby and immediately available. On 09/19/18 at 11:15 am, the following Plan of Removal was received and accepted.	A 064		

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A 064	Continued From page 109 1. The Administrator is researching the cost of a sprinkler system verses the cost of hiring more employees. 2. The Administrator is available as a second caregiver and will begin hiring more caregivers to comply with the FSES and plans to have new employee's hired by 10/15/18. 3. The FSES evaluations and rating scores will be completed at the time of admission, discharge, and any change of conditions. The Administrator was informed that the Class B Deficiency was lifted at this time. Based on record request and interview the facility failed to ensure that they maintained a Fire Safety Equivalency System (FSES) rating score of prompt (1.5 or below) as required for facilities that do not have a sprinkler system. This deficient practice has the potential for the 7 (R #s 2, 3, 5-9) residents identified on the resident census list, provided by the Administrator on 09/11/18, to be at risk of injury or death if a fire or other emergency that requires evacuation occurs. The findings are: A. Record request for the facility's Fire Safety Equivalency Score (FSES) forms, revealed there were no forms available to review. B. On 09/11/18 at 2:45 pm, during an interview with the Administrator, she confirmed that there were no (FSES) forms available to review. She stated she has not used the forms in a very long time. C. Record review of the FSES forms completed by the Administrator on 09/11/18 revealed, an evacuation rating score of 4.24 (slow).	A 064		

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A 064	Continued From page 110 D. On 09/11/18 at 3:30 pm, during an interview with the Administrator, she confirmed that based on her evaluation of the residents the evacuation rating score was 4.24 which would require 3 Direct Care Staff (DCS) on duty, awake, and immediately available 24/7 to reach a "prompt" rating score. The Administrator requested that a DCS complete the resident evacuation forms, since they know the residents better. E. Record review of the FSES forms completed by DCS #3 were reviewed/changes made by the Administrator, the evacuation score was 3.04 (slow) which would require 2 DCS on duty, awake and immediately available 24/7 and 1 DCS nearby and immediately available to reach a rating score of 1.08 (prompt). F. On 09/19/18 at 3:30 pm, during an interview with the Administrator, she confirmed that based of the FSES evacuation rating score 2 DCS will need to be on duty, awake and immediately available 24/7 and 1 DCS nearby and immediately available to "prompt" rating score of 1.08.	A 064		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show:	A 065		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 065	Continued From page 111 (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 A Based on record review and interview the facility failed to ensure fire drills had been conducted monthly on each 8 hour shift (morning, afternoon/evening, and graveyard) each quarter. This deficient practice has the potential for all 7 (R #s 2, 3, 5-9) residents listed on the census, provided by the Administrator on 09/11/18, to be at risk of harm. injury, and/or death if the Direct Care Staff (DCS) have not received training on how to respond and safely evacuate the residents in a controlled manner, if a fire or or other emergency that requires evacuation were to occur. The findings are: A. Record request for the facility's fire drill records revealed, no documentation of any fire drills having been conducted. B. On 09/12/18 at 11:15 am, during an interview with the Administrator, she confirmed that there have not been any recent fire drills conducted at the facility and does not know when the last one	A 065		

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A 065	Continued From page 112 was conducted.	A 065		
A 066	7 NMAC 8.2.66 Staff and Resident Fire and Safety Training STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff of the facility shall know the location and the proper use of fire extinguishers and the other procedures to be followed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff shall be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident admitted to the facility shall be given an orientation tour of the facility to include the location of the exits, fire extinguishers and telephones and shall be instructed in the actions to be taken in case of fire or other emergencies. D. Fire drill procedures. The facility must conduct at least one (1) fire drill each month. (1) Fire drills shall be held at different times of the day, evening and night. (2) The fire alarm system or detector system in the facility shall be used in the fire drills. During the night, the fire drill alarm may be silenced. (3) During the fire drills, emphasis shall be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall	A 066		

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A 066	Continued From page 113 show the date and time of the drill, the number of personnel participating in the drill, any problem(s) noted during the drill and the evacuation time in total minutes. (5) The local fire department may be requested to supervise and participate in the fire drills. [7.8.2.66 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.66 A C D (1) Bases on record review and interview the facility failed to ensure that: 1. The Direct Care Staff (DCS) have received fire safety and evacuation training at orientation and annual training. 2. Residents/Family members received fire safety and evacuation training that included a tour of the facility, the location of the exits, fire extinguishers, and telephones, and were instructed in the actions need to be taken in case of fire or other emergencies that require evacuation upon admission. 3. At least 1 fire drill was conducted every month, on each shift (morning, afternoon/evening, and graveyard shifts). These deficient practices have the potential for all 7 (R #s 2, 3, 5-9) residents listed on the census, provided by the Administrator on 09/11/18 and all occupants to be at risk of harm, injury, or death if a fire or other emergency were occur because: 1. The DCS have not received fire safety and evacuation training and do not know how to	A 066		

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A 066	Continued From page 114 safely evacuate the residents and other occupants of the facility. 2. Residents/family members do not know where the fire safety equipment is, the evacuation route, and/or where the exits are. 3. If fire drills are not conducted monthly to ensure staff and residents/family know how, when, and where to evacuate. The findings are: Findings related to DCS training: A. Record review of the training records for DCS #s 1-3 revealed, no documentation that they received any fire safety and evacuation training at orientation or annually. B. On 09/11/18 at 1:15 pm, during an interview with the Administrator, she confirmed that DCS #s 1-3 had not received any fire safety and evacuation training at orientation or annually. Findings related to resident/family training: C. Record review of R #'s 1-4's Admission Agreements revealed, no documentation that residents and/or families received any fire safety and evacuation training upon admission. D. On 09/13/18 at 4:17 pm, during an interview with the Administrator, she confirmed that neither residents and/or families received any fire safety and evacuation training upon admission. Findings related to fire drills: E. Record request for the facility's fire drill records revealed, no documentation of any fire	A 066		

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A 066	Continued From page 115 drills having been conducted. F. On 09/12/18 at 11:15 am, during an interview with the Administrator, she confirmed that there have not been any recent fire drills conducted at the facility and does not know when the last one was conducted.	A 066		
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 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.	A 068		

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A 068	Continued From page 116 (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. (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.	A 068		

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A 068	Continued From page 117 (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 (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	A 068		

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A 068	Continued From page 118 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 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.).	A 068		

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A 068	Continued From page 119 (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. 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]	A 068		

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A 068	Continued From page 120 This REQUIREMENT is not met as evidenced by: 7.8.2.68 B (1) D (2) (6) Based on record review and interview the facility failed to ensure that 1 (DCS #1) of 1 (DCS #1) Direct Care Staff who had been employed for over a year, received a minimum of 6 hours of palliative/hospice care training, to include 1 hour specific to the resident. This deficient practice has the potential for residents on hospice to be at risk of harm if residents who have elected to receive hospice services do not receive the palliative/end of life care care and services, because the DCS have not received the required 6 hours of annual palliative/hospice training. The findings are: A. Record review of DCS #1's (hire date 02/05/17) staff file revealed, no documentation that the required 6 hours of palliative/hospice care training, to include 1 hour specific to the resident was completed. B. On 09/11/18 at 1:15 pm, during an interview with the Administrator, she confirmed that DCS #1 (employed over 1 year) had not received the required 6 hours of palliative/hospice training. She stated that she has not provided palliative/hospice training for any of the DCS.	A 068		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule	A 070		

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A 070	Continued From page 121 are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.70 D, E, F 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	A 070		

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A 070	Continued From page 122 abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee 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	A 070		

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A 070	Continued From page 123 registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] 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	A 070		

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A 070	Continued From page 124 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 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	A 070		

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	2043	A. BUILDING: _____ B. WING _____	09/14/2018

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A 070	Continued From page 125 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 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	A 070		

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A 070	Continued From page 126 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. 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 incident or allegation of an incident or the next	A 070		

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A 070	Continued From page 127 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: 1. Employee Abuse Registry (EAR) clearances were received prior to hire. 2. The application and fingerprints for the Caregiver Criminal History Screening program (CCHSP) were submitted within 20 days of the date of hire were submitted within twenty (20) days of hire. 3. Documentation/proof of the applications, fingerprints, and clearances were maintained and available for review. 4. Incidents of abuse, neglect, and exploitation including medication errors and unusual occurrences were reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. This deficient practice has the potential to affect the safety and welfare of all 7 (R #s 2, 3, 5-9) current residents if: 1. Their care and services are being provided by staff with a previous history of abusing, neglecting, or exploiting residents and/or has a felony conviction. 2. Incidents of abuse, neglect, and exploitation including medication errors and unusual occurrences were not reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. The findings are:	A 070		

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A 070	Continued From page 128 Findings related to EAR/CCHSP: A. Record review of the Employee Abuse Registry (EAR) report for Direct Care Staff (DCS) #1 (hire date 02/05/17) dated 11/21/17 revealed, that her EAR application and clearance were not submitted/received prior to hire. B. Record review of the EAR report for DCS #1 (hire date 02/05/17) dated 12/06/17, revealed that her CCHSP application and fingerprints were not submitted within twenty (20) days after hire. C. Record review of the Employee Abuse Registry (EAR) report for DCS #3 (hire date 07/20/18) revealed that her EAR application and clearance were not submitted/received prior to hire. D. Record review of the EAR report for DCS #3 (hire date 07/20/18) dated 08/16/18, revealed that her CCHSP application and fingerprints were not submitted within twenty (20) days after hire. Findings related to Incident Reporting: Findings related to R #1: E. Record review of a complaint Intake dated (06/07/18) revealed, that during a [redacted] by the hospice nurse on [redacted]/18, 4 patches of [redacted] were found on R #1's body when there should have been only [redacted] F. Record review of the Record book of Prescriptions (03/25/no year) revealed, the direction for use for [redacted]	A 070		

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A 070	Continued From page 129 [redacted] G. On 09/12/18 at 11:15 am, during an interview with the Administrator, she confirmed that the hospice nurse found [redacted] R #1 instead of [redacted] The Administrator confirmed she did not report the medication error to the Licensing Authority as required. H. On 09/12/18 at 2:24 pm, during an interview with [name of hospice director], she confirmed that [name of nurse] found [redacted] on R #1's body on [redacted]/18. Findings related to R #s 7 & 8: I. Record review of R #7's resident file reveal, a note (not dated) stating that on [redacted]/17 at 8:50 am R #7 [redacted] on the curb outside the facility, [redacted]. There was no documentation of an internal incident report or that the [redacted] was reported to the Licensing Authority. J. Record review of R #8's progress notes (dated [redacted]/18) revealed, that [redacted] claimed that DCS #5 [redacted] There was no documentation of an internal incident report or that the possible [redacted] by DCS # 5 was reported to the Licensing Authority. K. Record request for the facility's internal & state incident reports, revealed there were not any reports available for review. L. On 09/19/18 at 2:05 pm, during an interview	A 070		

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A 070	Continued From page 130 with the Administrator, she stated that there are no internal incident reports available for review for R #s 7 & 8, that incidents are only documented in the resident's progress notes. M. On 09/12/18 at 2:15 pm, during an interview with the Administrator, she confirmed that there were no internal or state incidents available for review. She stated that she stopped reporting incidents to the Licensing Authority years ago.	A 070		