

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5881	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2020
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NAME OF PROVIDER OR SUPPLIER CASA CONTENTA ASSISTED LIVING, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4805 SOMBERETE ROAD SE RIO RANCHO, NM 87124
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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 000	Initial Comments The following deficiencies were cited during a Full Onsite survey completed on 01/15/20 for the New Mexico State Requirements for Assisted Living Facilities for Adults 7 NMAC 8.2.	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC. B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant	A 016		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE
03/25/20

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A 016	<p>Continued From page 1</p> <p>training, or experience to provide for the needs of the residents;</p> <p>(3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and</p> <p>(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;</p> <p>(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:</p> <p>(a) a valid New Mexico driver's license with the appropriate classification for the vehicle that is used to transport residents;</p> <p>(b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation;</p> <p>(c) proof of insurance; and</p> <p>(d) documentation of a clean driving record;</p> <p>(6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and</p> <p>(7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC.</p> <p>[7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by:</p>	A 016		

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A 016	<p>Continued From page 2</p> <p>7.8.2.16 B (3) (7)</p> <p>Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	A 016		

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A 016	<p>Continued From page 3</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	A 016		

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A 016	<p>Continued From page 4</p> <p>[7.1.12.8 NMAC - N, 01/01/2006]</p> <p>7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: ...</p> <p>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.</p> <p>(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.</p> <p>(2) A signed authorization for release of information form.</p> <p>(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.</p> <p>(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.</p> <p>...</p>	A 016		

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A 016	<p>Continued From page 5</p> <p>E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules.</p> <p>The fees will not be applied to any other activity or expense undertaken by the department.</p> <p>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.</p> <p>G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules.</p>	A 016		

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A 016	<p>Continued From page 6</p> <p>(1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification.</p> <p>(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.</p> <p>Based on record review and interview the facility failed to ensure that:</p> <ol style="list-style-type: none"> 1. Staff 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. <p>This deficient practice has the potential to affect the safety and welfare of all 4 (R #s 1-4) residents on the census provided by the Administrator on 01/13/20 if they are being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents. The findings are:</p> <p>A. Record review of Direct Care Staff (DCS #4's) (rehire date: 03/25/19) employee file revealed, no documentation that the EAR application was ever submitted. There was no documentation that the</p>	A 016		

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A 016	Continued From page 7 fingerprints were ever submitted to the CCHSP and no clearance letter in the file. B. On 01/15/20 at 9:30 am, during an interview, the Administrator confirmed the findings listed above related to EAR and CCHSP clearance for DCS #4. .	A 016		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care;	A 017		

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A 017	<p>Continued From page 8</p> <p>(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.</p> <p>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]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.17 A C (1-3) (a-e) (4-12)</p> <p>Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS) received all required supervised, orientation, and annual trainings. This deficient practice has the potential for all 4 (R #s 1-4) residents listed on the census provided by the Administrator on 01/13/20, to be at risk of harm or injury, if staff have not received training on the methods of providing care and services. The findings are:</p> <p>A. Record review of DCS #1's (hire date 03/01/14) staff file revealed no documentation of receiving the following trainings:</p> <ol style="list-style-type: none"> 1. Sixteen (16) hours of supervised training before providing unsupervised care. 2. Orientation/Annual training for smoking policy. <p>B. Record review of DCS #2's (hire date 07/30/16) staff file revealed no documentation of receiving the following trainings:</p>	A 017		

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A 017	<p>Continued From page 9</p> <ol style="list-style-type: none"> 1. Sixteen (16) hours of supervised training before providing unsupervised care. 2. Annual trainings from 07/30/16 to 07/29/17 listed below: <ol style="list-style-type: none"> a. Fire safety and evacuation training b. First aid c. Safe food handling practices (for persons involved in food preparation) to include: <ol style="list-style-type: none"> i. Instructions in proper storage. ii. Preparation and serving of food. iii. Safety in food handling. iv. Appropriate personal hygiene. v. Infectious and communicable disease control. d. Confidentiality of records and resident information. e. Infection control. f. Resident rights. g. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. h. Smoking policy <ol style="list-style-type: none"> i. Methods to provide quality resident care. j. Emergency procedures. k. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist with ISPs. <p>C. Record review of DCS #3's (hire date 11/10/17) staff file revealed no documentation of receiving the following trainings:</p> <ol style="list-style-type: none"> 1. Sixteen (16) hours of supervised training before providing unsupervised care. 2. Orientation/Annual training for smoking policy <p>D. Record review of DCS #4's (rehire date 03/25/19) staff file revealed no documentation of</p>	A 017		

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A 017	Continued From page 10 receiving the sixteen (16) hours of supervised training before providing unsupervised care. E. On 01/15/20 at 9:30 am, during an interview, the Administrator confirmed that the above trainings had not been completed by DCS #s 1-4.	A 017		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior;	A 025		

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A 025	<p>Continued From page 11</p> <p>(9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc.</p> <p>D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually.</p> <p>E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.25 A</p> <p>Based on record review and interview, the facility failed to ensure for 3 (R #s 2-4) of 4 (R#s 1-4) whose evaluations were reviewed for compliance that initial resident evaluations were completed within fifteen (15) days prior to admission. This</p>	A 025		

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A 025	<p>Continued From page 12</p> <p>deficient practice has the potential for all residents to be at risk of not receiving the appropriate care and services upon admission. The findings are:</p> <p>A. Record review of R #2's (admission date [REDACTED]/16) initial Evaluation/Assessment dated [REDACTED]/16 revealed it was not completed within 15 days prior to admission.</p> <p>B. Record review of R #3's (admissions date [REDACTED]/19) initial Evaluation/Assessment dated [REDACTED]/19 revealed it was not completed within 15 days prior to admission</p> <p>C. Record review of R #4's (admissions date [REDACTED]/19) initial Evaluation/Assessment dated [REDACTED]/19 revealed it was not completed within 15 days prior to admission</p> <p>D. On 01/14/20 at 2:35 pm, during an interview, the Administrator confirmed the above listed findings for R #s 2-4 initial Evaluations/Assessments.</p>	A 025		
A 026	<p>7 NMAC 8.2.26 Individual Service Plan</p> <p>INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility.</p> <p>A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation.</p> <p>(1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies.</p> <p>(2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed</p>	A 026		

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NAME OF PROVIDER OR SUPPLIER CASA CONTENTA ASSISTED LIVING, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4805 SOMBERETE ROAD SE RIO RANCHO, NM 87124
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A 026	<p>Continued From page 13</p> <p>practical nurse, registered nurse or a physician extender.</p> <p>(3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident's health status.</p> <p>B. The ISP shall include the following:</p> <p>(1) a description of identified needs as noted in the resident evaluation;</p> <p>(2) a written description of all services to be provided;</p> <p>(3) who will provide the services;</p> <p>(4) when or how often the services will be provided;</p> <p>(5) how the services will be provided;</p> <p>(6) where the services will be provided;</p> <p>(7) expected goals and outcomes of the services;</p> <p>(8) documentation of the facility's determination that it is able to meet the needs of the resident;</p> <p>(9) the level of assistance that the resident will require with activities of daily living and with medications;</p> <p>(10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and</p> <p>(11) current orders for all medications, including those authorized for PRN usage.</p> <p>[7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.26 A</p> <p>Based on record review and interview, the facility failed to ensure for 3 (R #s 2-4) of 4 (R #s 1-4) residents whose Individual Service Plans (ISP's) were reviewed for compliance had been completed within ten (10) calendar days of</p>	A 026		

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A 026	<p>Continued From page 14</p> <p>admission. This deficient practice has the potential for residents to be at risk of harm or injury if Direct Care Staff (DCS) are not providing the correct care and services needed. The findings are:</p> <p>A. Record review of R #2's resident file revealed an:</p> <ol style="list-style-type: none"> 1. Admission date of [REDACTED]/16. 2. Initial ISP that was not completed until [REDACTED]/17. <p>B. Record review of R #3's resident file revealed an:</p> <ol style="list-style-type: none"> 1. Admission date of [REDACTED]/19. 2. Initial ISP that was not completed until [REDACTED] 19. <p>C. Record review of R #4's resident file revealed an:</p> <ol style="list-style-type: none"> 1. Admission date of [REDACTED]/19. 2. Initial ISP that was not completed until [REDACTED]/19. <p>D. On 01/14/20 at 2:35 pm, during an interview with the Administrator, she confirmed that the initial ISP's for R #s 2-4 were not completed within 10 days after admission.</p>	A 026		
A 035	<p>7 NMAC 8.2.35 Medication</p> <p>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</p>	A 035		

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A 035	<p>Continued From page 15</p> <p>assistant or nurse practitioner and with entry into the resident's record.</p> <p>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.</p> <p>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 certified by the state board of nursing.</p> <p>C. PRN (pro re nada) medication.</p> <p>(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.</p> <p>(2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP.</p> <p>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.</p> <p>E. The facility shall have medication reference material that contains information relating to drug</p>	A 035		

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A 035	<p>Continued From page 16</p> <p>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.</p> <p>F. Medications prescribed for one resident shall not be used for another resident.</p> <p>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:</p> <ol style="list-style-type: none"> (1) the resident's name; (2) any known allergies to medication that the 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 	A 035		

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A 035	<p>Continued From page 17</p> <p>required by the medication order;</p> <p>(15) the date and time that the medication is self-administered, administered with assistance or is administered;</p> <p>(16) the initials and signature of the person assisting with or administering the medication;</p> <p>(17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.);</p> <p>(18) any refused dose of medication;</p> <p>(19) any missed dose of medication; and</p> <p>(20) any medication error.</p> <p>H. No medication shall be stopped or started without specific orders from the primary care physician.</p> <p>I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber.</p> <p>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.</p> <p>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:</p> <p>(1) the resident's name;</p> <p>(2) the name of the medication;</p> <p>(3) the date that the prescription was issued;</p> <p>(4) the prescribed dosage and the instructions for administration of the medication; and</p> <p>(5) the name and title of the prescriber.</p> <p>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.</p>	A 035		

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A 035	<p>Continued From page 18</p> <p>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.</p> <p>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]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (5, 19)</p> <p>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 Medication Administration Records (MARs) were reviewed for compliance included:</p> <ol style="list-style-type: none"> 1. Both the brand/generic names for the medications. 2. Documentation of any missed doses of medication. <p>This deficient practice has the potential for all residents listed on the resident census provided by the Administrator on 01/13/20 to be at risk of harm if medication errors occur because the Direct Care Staff (DCS) who assist residents with the self administration of their medications do not know:</p> <ol style="list-style-type: none"> 1. Both the brand/generic names for the medications. 2. If residents have missed any doses of medication. 	A 035		

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A 035	<p>Continued From page 19</p> <p>The findings are:</p> <p>A. Record review of R #1's [REDACTED] /20 to [REDACTED] /20 MAR revealed that it did not include:</p> <ol style="list-style-type: none"> Both the brand and generic names for the following medications: [REDACTED] No documentation of notes/reasons for the following missed doses of medication: [REDACTED] <p>B. Record review of R #2's [REDACTED] /2020 to [REDACTED] /20 MAR revealed that it did not include both the brand and generic names for the following medications: [REDACTED]</p> <p>C. Record review of R #3's [REDACTED] /2020 to [REDACTED] /20 MAR revealed that it did not include both the brand and generic names for the following medications: [REDACTED]</p> <p>D. Record review of R #2's 01/01/2020 to 01/15/20 MAR revealed that it did not include</p>	A 035		

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A 035	Continued From page 20 both the brand and generic names for the medication Erythromycin ointment (eye infection) E. On 01/15/20 at 11:05 am, during an interview with the Administrator, she confirmed the MAR findings listed above for R #s 1-4.	A 035		
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 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	A 049		

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A 049	<p>Continued From page 21</p> <p>least one and three-quarters (1 3/4) inch solid core construction.</p> <p>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.</p> <p>E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside.</p> <p>F. All doors shall readily open from the inside.</p> <p>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]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.49 A (1)</p> <p>Based on observation and interview, the facility failed to ensure that the lock on the back emergency exit door could be operated by all residents/occupants. This deficient practice has the potential for all 4 (R #s 1-4) residents identified on the census provided by the Administrator on 01/13/20, to be at risk of harm, injury, or death if a fire or other emergency requiring evacuation were to occur and residents/occupants are unable to exit the facility.</p> <p>The findings are:</p> <p>A. On 01/15/20 at 10:10 am, during observation of the back exit door, it was observed the door was locked and had a dead bolt lock that could not be unlocked by all residents and/or occupants of the facility.</p>	A 049		

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A 049	Continued From page 22 B. On 01/15/20 at 10:15 am, during an interview with the Administrator, he confirmed that the back emergency exit door had a dead bolt lock that could not be unlocked by all residents and/or occupants of the facility.	A 049		
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	A 066		

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A 066	<p>Continued From page 23</p> <p>upon orderly evacuation under proper discipline rather than upon speed.</p> <p>(4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall 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.</p> <p>(5) The local fire department may be requested to supervise and participate in the fire drills.</p> <p>[7.8.2.66 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.66 A B C</p> <p>Bases on record review and interview, the facility failed to ensure that:</p> <ol style="list-style-type: none"> 1. The Direct Care Staff (DCS) had received fire safety and evacuation training at orientation and annually. 2. Residents/Family members received fire safety and evacuation orientation upon admission to the facility. <p>These deficient practices could likely cause all 4 (R #s 1-4) residents listed on the census, provided by the Administrator on 01/13/20, DCS, and all occupants, to be at risk of harm, injury, or death if a fire or other emergency were to occur because:</p> <ol style="list-style-type: none"> 1. The DCS do not know how to 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. The findings 	A 066		

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A 066	<p>Continued From page 24</p> <p>are:</p> <p>Findings related to resident and family training on how to evacuate safely:</p> <p>A. Record review of R #s 1-4) resident files revealed no documentation that they received Fire Safety and Evacuation orientation upon admission to the facility.</p> <p>B. On 01/15/20 at 9:50 am, during an interview with the Administrator, she confirmed that there was no documentation that R #s 1-4 received fire safety and evacuation orientation upon admission.</p> <p>Findings related to staff training</p> <p>C. Record review of Direct Care Staff (DCS #s 1-4) training files revealed no documentation that they had received Fire Safety and Evacuation training at orientation and/or annually.</p> <p>D. On 01/15/20 at 9:50 am, during an interview with the Administrator, she confirmed that there was no documentation that the DCS #s 1-4 had received Fire Safety and Evacuation training at orientation and/or annually.</p>	A 066		
A 068	<p>7 NMAC 8.2.68 Hospice</p> <p>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.</p> <p>A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following</p>	A 068		

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NAME OF PROVIDER OR SUPPLIER CASA CONTENTA ASSISTED LIVING, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4805 SOMBERETE ROAD SE RIO RANCHO, NM 87124
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A 068	<p>Continued From page 25</p> <p>definitions shall also apply.</p> <p>(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.</p> <p>(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.</p> <p>(3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live.</p>	A 068		

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A 068	<p>Continued From page 26</p> <p>(8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination.</p> <p>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:</p> <p>(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</p> <p>(2) offer an ongoing employee psychological support program for end of life care issues.</p> <p>C. Individual service plan (ISP) requirements.</p> <p>(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.</p> <p>(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:</p> <p>(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;</p> <p>(b) what services are to be provided;</p> <p>(c) who will provide the services;</p> <p>(d) how the services will be provided;</p> <p>(e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process;</p> <p>(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</p>	A 068		

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A 068	<p>Continued From page 27</p> <p>(g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them.</p> <p>(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:</p> <p>(a) a physician;</p> <p>(b) a physician extender (PA or NP);</p> <p>(c) a licensed nurse (RN or LPN);</p> <p>(d) the resident if their PCP has approved it;</p> <p>(e) family or family designee; and</p> <p>(f) any other individual in accordance with applicable state and local laws.</p> <p>D. Care coordination.</p> <p>(1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC.</p> <p>(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.</p> <p>(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.</p> <p>(a) The facility shall provide individual records for each resident.</p> <p>(b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record.</p> <p>(4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall</p>	A 068		

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A 068	<p>Continued From page 28</p> <p>support the resident ' s freedom of choice with regard to decisions.</p> <p>(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.</p> <p>(6) The assisted living facility shall ensure the coordination of services with the hospice agency.</p> <p>(a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs.</p> <p>(b) The assisted living facility shall receive information and communication from the hospice staff at each visit.</p> <p>(i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.).</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(i) The process may be informal or formal depending on the nature of the issue.</p> <p>(ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified.</p>	A 068		

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A 068	<p>Continued From page 29</p> <p>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.</p> <p>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]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.68 B (1)</p> <p>Based on record review and interview, the facility failed to ensure that Direct Care Staff (DCS) had received the required six (6) hours of palliative/hospice training including one hour specific to resident's Individual Service Plan (ISP) annually when the facility is providing care and services for hospice residents.</p> <p>This deficient practice has the potential for 2 (R #s 3 & 4) residents identified as receiving hospice services by the Administrator on 01/13/20, to be at risk of harm or injury if DCS do not know the proper methods of providing care and services.</p>	A 068		

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A 068	<p>Continued From page 30</p> <p>The findings are:</p> <p>A. Record review of DCS #s 1-4 employee files revealed no documentation of receiving 6 hours of Palliative/Hospice care training in the past year.</p> <p>B. On 01/15/20 at 9:30 am, during an interview, the Administrator confirmed that DCS #s 1-4 had not received the required 6 hours of palliative/hospice care training in the past year.</p>	A 068		