

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  2039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R-C 02/23/2017
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NAME OF PROVIDER OR SUPPLIER  SIERRA SPRINGS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 503 LOS LENTES ROAD NE LOS LUNAS, NM 87031
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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
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{A 000}	Initial Comments  The following deficiencies were cited as a result of a revisit survey/follow-up survey completed on 02/23/17 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.	{A 000}		
{A 025}	7 NMAC 8.2.25 Resident Evaluation  RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident's functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident's health status. C. The resident's evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses;	{A 025}	<i>In order to correct the violation of not having a resident evaluation for each resident that is signed by a LPN, RN or PE, we had all of our evaluations reviewed and signed by an RN on 3/23/17. She has returned since since then to review evaluation for our two new residents. To ensure that a resident evaluation is completed <sup>within</sup> 15 days prior to admission of a new resident the administrator will set up/schedule an evaluation within</i>	

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

*Francis Johnson*

TITLE

*Administrator*

(X6) DATE

*7/19/17*

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[A 025]	<p>Continued From page 1</p> <p>(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. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.25 A B C E</p> <p>This is an uncorrected deficiency from a survey dated 08/11/15</p> <p>Based on record review and interview the facility failed to ensure that for 3 (R #s 2-4) of 3 (R #s 2-4) residents the evaluations were:</p> <ol style="list-style-type: none"> <li>1. Completed within 15 days prior to</li> </ol>	[A 025]	<p>15 days prior to the admission date. In order to ensure ongoing compliance, the statement, "A resident evaluation must be completed by the administrator within 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." will be added to the admission agreement.</p> <p>In order to ensure that the resident evaluations are reviewed every six months or when there is a significant change, the resident's evaluations will be reviewed the last week of every month by the administrator. The administrator will</p>	
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{A 025}	<p>Continued From page 2</p> <p>admission.</p> <p>2. Reviewed and updated at a minimum of every 6 months or when there is a significant change in the resident's health status.</p> <p>3. Reviewed by a licensed practical nurse (LPN), registered nurse (RN), or a physician extender (PE).</p> <p>This deficient practices has the potential for residents to be at risk of not receiving the appropriate care and assistance they need. The findings are:</p> <p>A. Record review of R #2's evaluation dated 08/01/16 - 01/31/17 revealed, no date or signature of the person evaluating the resident.</p> <p>B. Record review of R #3's evaluation dated 08/12/16 - 01/31/17 revealed, no date or signature of the person evaluating the resident.</p> <p>C. Record review of R #4's evaluation dated 04/16/16 revealed, the evaluation had not been reviewed or updated at six months.</p> <p>D. On 02/23/17 at 12:45 pm, during an interview with the Administrator, she confirmed that the evaluation for R #2's and R #3's evaluations were not signed and dated or reviewed by a LPN, RN, or PE. R #4's evaluation was not updated at six months. She also stated that she has just hired a new contract nurse.</p>	{A 025}	<p><i>also review the date of the nurse last review and contact her one month prior to the 6 month review requirement to schedule a review 2/1/17</i></p>	
{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>	{A 026}	<p><i>In order to correct the violation of not having our ISP's reviewed by a LPN, RN or PE we</i></p>	

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{A 026}	<p>Continued From page 3</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 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>	{A 026}	<p><i>had all of our ISPs reviewed and signed by an RN on 3/23/17. She has returned twice since then to review the ISP for two new residents. To ensure that a resident ISP for a new admit is reviewed and signed by an RN within 10 days of admission, the administrator will contact the RN on admission day (first day as a resident to set up schedule the review. In order to ensure ongoing compliance the statement of an ISP shall be developed and implemented within 10 days of admission. The ISP will be reviewed and or revised at a minimum of every six months"</i></p>	
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(A 026)	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (2) (3)</p> <p>This is an uncorrected deficiency from a survey dated 08/11/15</p> <p>Based on record review and interview the facility failed to ensure for 3 (R #s 2-4) of 3 (R #s 2-4) residents that:</p> <ol style="list-style-type: none"> <li>1. The Individual Service Plan (ISP) is reviewed and revised by a licensed practical nurse (LPN), registered nurse (RN) or a physician extender (PE).</li> <li>2. The ISP is reviewed and/or revised at a minimum of every 6 months.</li> </ol> <p>These deficient practices have the potential for residents to be at risk of not receiving the appropriate care and assistance they need as changes in their health status occurs due to the ISP not being completed and reviewed as required. The findings are:</p> <p>A. Record review of R #2's ISP dated 08/04/16 - 01/31/17 revealed, the ISP was not signed or dated by the person reviewing the ISP.</p> <p>B. Record review of R #3's ISP dated 08/12/16 - 01/31/17 revealed, the ISP was not signed or dated by the person reviewing the ISP.</p> <p>C. Record review of R #4's ISP dated 04/15/16 revealed, the ISP was not reviewed and/or revised at a minimum of six (6) months.</p> <p>D. On 02/23/17 at 12:45 pm, during an interview with the Administrator, she confirmed that R #s 2 and 3's evaluations were not signed and dated or reviewed by a LPN, RN, or PE. She also</p>	(A 026)	<p><i>will be added to the admission agreement. In order to ensure that the LBP's are reviewed every six months or when there is a significant change, the LBP's will be reviewed the last week of every month by the administrator. The administrator will also review the state of the nurses last review and contact her one month prior to the 6 month review requirement to schedule a review by the RN.</i></p>	<p><i>8/1/17</i></p>

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{A 026}	Continued From page 5  stated that R #4 's Evaluation was not reviewed and/or revised at (6) months.	{A 026}		
{A 034}	7 NMAC 8.2.34 Custodial Drug Permits  CUSTODIAL DRUG PERMITS. A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications 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	{A 034}	<i>In order to correct the violation of not storing oxygen cylinder tanks in a room free from combustibles we purchased a plastic storage unit that we placed outside, under the front porch. The plastic storage unit has a keypad lock and cylinder racks inside. We will post a sign on the employee message board that states, "All oxygen tanks not in use must be stored in the oxygen cylinder storage unit."</i>	

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{A 034}	<p>Continued From page 6</p> <p>own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate.</p> <p>(6) The facility shall not require the residents to purchase medications from any particular pharmacy.</p> <p>(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.</p> <p>(8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document:</p> <p>(a) the type and strength of the schedule II through IV drugs;</p> <p>(b) the date and time staff assisted with self-administration;</p> <p>(c) the resident's name;</p> <p>(d) the prescriber's name;</p> <p>(e) the dose;</p> <p>(f) the signature of the person assisting with delivery of the medication; and</p> <p>(g) the balance of medication remaining.</p> <p>(9) Any remaining medication discontinued by a physician's order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC.</p> <p>(10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility.</p> <p>B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following</p>	{A034}	<p><i>we posted a sign that states "oxygen in use no smoking no open flame" on each bedroom door. The signs were placed on each door so that when new residents come in on oxygen the staff won't forget to place a sign on the door and to ensure that everyone, including visitors, knows that smoking and open flame (candles) are not allowed in the rooms. The administrator will monitor the signs to ensure they are not removed from the door, message board or storage unit. dl/17</i></p>	

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{A 034}	<p>Continued From page 7</p> <p>oversight and guidance.</p> <p>(1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours.</p> <p>(2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation.</p> <p>(3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications.</p> <p>(4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (7)</p> <p>Reference NFPA 99, 1999 Edition</p> <p>Section 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) * Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both) 1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no</p>	{A 034}		

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{A 034}	<p>Continued From page 8</p> <p>case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin.</p> <p>2. Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose.</p> <p>3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation.</p> <p>4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage.</p> <p>5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [see also 4-3.1.1.2(a)7].</p> <p>6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat.</p> <p>7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide.</p>	{A 034}		

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{A 034}	<p>Continued From page 9</p> <p>Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders.</p> <p>8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use.</p> <p>9. Containers shall not be stored in a tightly closed space such as a closet [see 8-2.1.2.3(c)].</p> <p>Reference NFPA 99, 1999 Edition Section 8-3.1.11.3 (Signs)</p> <p>This is an uncorrected deficiency from a survey dated 08/11/15</p> <p>Based on observation and interview, the facility failed to ensure that:</p> <ol style="list-style-type: none"> <li>1. Oxygen cylinder tanks were stored in a room free from combustibles.</li> <li>2. "Oxygen in Use" signs were posted on the doors of residents using oxygen.</li> </ol> <p>These deficient practices may cause injury or death to all 14 (R #s 1-14) residents identified on the census provided by the Administrator on 02/23/17, if a fire was to occur and the oxygen cylinder tanks stored with combustibles accelerated a fire and if there are no warning signs posted informing there is "oxygen in use" in the event there was a fire. The findings are:</p> <p>A. On 02/23/17 at 10:45 am, during a tour of the facility, observation of the facility's laundry room was observed to have thirty-two (32) oxygen cylinder tanks stored in the room which contained articles of clean clothing and linens and no "oxygen in use" sign posted on the door of R #5's room were oxygen was being used.</p>	{A 034}		

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{A 034}	Continued From page 10  B. On 02/23/17 at 11:15 am, during an interview with the Administrator, she confirmed that thirty-two (32) oxygen cylinder tanks were stored in the laundry room with clean clothing and linens and that R #5's room did not have an "oxygen in use" sign posted on the door where oxygen is being used.	{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 certified by the state board of nursing.	{A 035}	<i>In order to correct the violation of not having all the signatures of the medication assistants on each page of the mar we developed a form that will be attached to the new mars for the month that states, "I have signed and initialed the end of each of the resident's medication record, signature and date." A form will be placed in the</i>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  2039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 02/23/2017
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NAME OF PROVIDER OR SUPPLIER  SIERRA SPRINGS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 503 LOS LENTES ROAD NE LOS LUNAS, NM 87031
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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
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{A 035}	<p>Continued From page 11</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 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> <p>(1) the resident's name;</p> <p>(2) any known allergies to medication that the resident has;</p> <p>(3) the name of the resident's PCP or the</p>	{A 035}	<p>first section of the Mar. The Medication assistants will hand in in person or place in the administrators message box. When the administrator removes the old mar's from the MAR binder she will verify that all signatures are listed on the Mar. in order to correct the violation of medication assistants not documenting the desired results or problems encountered with the PRN medication we developed a separate form that lists the resident's name, the PRN medication and the statement "After</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  2039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R-C 02/23/2017
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NAME OF PROVIDER OR SUPPLIER  SIERRA SPRINGS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 603 LOS LENTES ROAD NE LOS LUNAS, NM 87031
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{A035}	<p>Continued From page 12</p> <p>prescriber of the medication;</p> <p>(4) the diagnosis or reason for the medication;</p> <p>(5) the name of the medication, including the drug product brand name and the generic name;</p> <p>(6) notation if the medication is a schedule II-IV drug;</p> <p>(7) the dosage of the medication;</p> <p>(8) the strength of the medication;</p> <p>(9) the frequency or how often the medication is to be taken or given;</p> <p>(10) the route of delivery for the medication (mouth, eye, ear, other);</p> <p>(11) the method of delivery for the medication (pills, drops, IM injection, other);</p> <p>(12) the date that the medication was started or discontinued;</p> <p>(13) any change in the medication order;</p> <p>(14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as 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</p>	{A035}	<p><i>assisting with this PRN medication, return to the resident one hour later to determine the result or problems encountered with the medication."</i></p> <p><i>Above the columns it states, "Result/ Problems encountered, Date and signature." In order to ensure that the medication assistants are filling out this form the administrator will also monitor the PRN results form as well when she removes the MARs at the end of the month and replace them with the new</i></p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  2039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R-C 02/23/2017
NAME OF PROVIDER OR SUPPLIER  SIERRA SPRINGS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 503 LOS LENTES ROAD NE LOS LUNAS, NM 87031		
(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 035)	Continued From page 13  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 G (16) (17)  This is an uncorrected deficiency from survey dated 08/11/15.	(A 035)	<i>Miss. A section will be added to the medication training program that reviews both of these forms and how to fill them out.</i>	2/1/17

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NAME OF PROVIDER OR SUPPLIER  SIERRA SPRINGS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 503 LOS LENTES ROAD NE LOS LUNAS, NM 87031
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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 035}	<p>Continued From page 14</p> <p>Based on record review and interview the facility failed to ensure for 1 (R # 5) of 4 (R #s 2-5) residents, whose January 2017 MARs (Medication Administration Records) were reviewed had the Direct Care Staff (DCS) signatures who assist with medications and the desired results obtained or problems encountered with any medications documented on the MAR. This deficient practice has the potential for residents to be at risk of not receiving the desired relief and outcomes, if staff are not documenting the results of PRN (as needed) medications and if the staff signatures are not on the MAR, the facility/residents may not be aware who is assisting with medications. The findings are:</p> <p>A. Record review of R# 5's MAR for January 2017 revealed, that the signatures of DCS who are assisting with medications are not listed and DCS assisting with PRN (as needed) medications are not documenting the desired results or problems encountered with the medications.</p> <p>B. On 02/23/2017 at 2:30 pm, during an interview with the Administrator, she confirmed that the January 2017 MAR for R #5 did not have the staff signatures and initials listed and staff assisting with PRN medication are not documenting the desired results/problems encountered with the medications.</p>	{A 035}		
{A 043}	<p>7 NMAC 8.2.43 Hazardous Areas</p> <p>HAZARDOUS AREAS: Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than one hundred (100) sq. ft., storage rooms more than fifty (50) sq. ft. but less than one hundred (100) sq. ft. not storing</p>	{A 043}		

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NAME OF PROVIDER OR SUPPLIER  SIERRA SPRINGS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 503 LOS LENTES ROAD NE LOS LUNAS, NM 87031
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{A043}	<p>Continued From page 15</p> <p>combustibles, storage rooms with more than one hundred (100) sq. ft. storing combustibles, chemical storage rooms with more than fifty (50) sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either:</p> <p>(1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter (3/4) hour rating; or</p> <p>(2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or</p> <p>(3) other hazardous areas shall be enclosed with walls with at least a twenty (20) minute fire rating and doors equivalent to one and three-quarter (1 3/4) inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection.</p> <p>B. Boiler, furnace or fuel fired water heater rooms. For facilities with four (4) or more residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one (1) hour. Doors to these rooms shall be one and three-quarter (1-3/4) inch solid core. [7.8.2.43 NMAC - Rp, 7.8.2.44 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (7)</p> <p>This is an uncorrected deficiency from a survey dated 08/11/15</p>	{A043}	<p><i>In order to correct the violation of not storing oxygen cylinder tanks in a room free from combustibles we purchased a plastic storage unit that was placed outside under the front porch. The plastic storage unit has a cylinder rack and is kept locked. We will post a sign on the employee message board that states, "all oxygen tanks not in use must be stored in the oxygen cylinder storage unit." We posted a sign that states, "Oxygen</i></p>	
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NAME OF PROVIDER OR SUPPLIER  SIERRA SPRINGS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 503 LOS LENTES ROAD NE LOS LUNAS, NM 87031
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{A 043}	<p>Continued From page 16</p> <p>Reference NFPA 99, 1999 Edition</p> <p>Section 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) * Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both)</p> <p>1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin.</p> <p>2. Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose.</p> <p>3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation.</p> <p>4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage.</p> <p>5. Storage locations for oxygen and nitrous oxide</p>	{A 043}	<p><i>in use. no smoking no open flame" on each bed room door.</i></p> <p><i>The signs were placed on each bed room door so that when new residents come in on oxygen the staff won't forget to place a sign on the door and also to ensure that everyone, including visitors, knows that smoking and open flame. (i.e. candles) are not allowed in the bedrooms. The administrator will monitor the signs to ensure that they are not removed from the doors,</i></p>	

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NAME OF PROVIDER OR SUPPLIER: **SIERRA SPRINGS ASSISTED LIVING**  
STREET ADDRESS, CITY, STATE, ZIP CODE: **503 LOS LENTES ROAD NE  
LOS LUNAS, NM 87031**

(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 043}	<p>Continued From page 17</p> <p>shall be kept free of flammable materials [see also 4-3.1.1.2(a)7].</p> <p>6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat.</p> <p>7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders.</p> <p>8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use.</p> <p>9. Containers shall not be stored in a tightly closed space such as a closet [see 8-2.1.2.3(c)].</p> <p>Reference NFPA 99, 1999 Edition Section 8-3.1.11.3 (Signs)</p> <p>Based on observation and interview, the facility failed to ensure that:</p> <ol style="list-style-type: none"> <li>Oxygen cylinder tanks were stored in a room free from combustibles.</li> <li>"Oxygen in Use" signs were posted on doors of residents using oxygen.</li> </ol> <p>These deficient practices may cause injury or death to all 14 (R #s 1-14) residents identified on the census provided by the Administrator on 02/23/17 if a fire was to occur and oxygen cylinder tanks stored with combustibles accelerated a fire and if there are no warning signs posted informing there is "oxygen in use" in the event there was a fire. The findings are:</p>	{A 043}	<i>messag board, or storage unit.</i>	<i>8/1/17</i>

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{A043}	Continued From page 18  A. On 02/23/17 at 10:45 am, during a tour of the facility, observation of the facility's laundry room was observed to have thirty-two (32) oxygen cylinder tanks stored in the room which contained articles of clean clothing and linens and no "oxygen in use" sign posted on the door of R #5's room where oxygen was being used.  B. On 02/23/17 at 11:15 am, during an interview with the Administrator, she confirmed that thirty-two (32) oxygen cylinder tanks were stored in the laundry room with clean clothing and linens and that R #5's room did not have an "oxygen in use" sign posted on the door where oxygen is being used.	{A043}		
{A044}	7 NMAC 8.2.44 Heating, Air-Conditioning and Ventilation  HEATING, AIR-CONDITIONING AND VENTILATION: A. Heating, air-conditioning, piping, boilers and ventilation equipment shall be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities shall have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. B. The heating method used by the facility shall provide a minimum temperature of seventy (70) degrees fahrenheit, measured at three (3) feet above the floor, in all rooms used by the residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device shall be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances shall be	{A044}	<i>In order to correct the violation of not ensuring that the gas furnace heater was inspected we had the gas furnace heater inspected on 6/21/2017. It was inspected by a local plumbing and heating company. In order to ensure continued compliance</i>	

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NAME OF PROVIDER OR SUPPLIER  <b>SIERRA SPRINGS ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 LOS LENTES ROAD NE LOS LUNAS, NM 87031</b>
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{A044}	<p>Continued From page 19</p> <p>permanently anchored and kept away from flammables such as curtains, bedcovering, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or presents danger from electrical shock. D. Fireplaces and open flame heating shall not be utilized in sleeping rooms. E. Gas fired water heaters shall not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms. F. The facility shall be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means. G. All openings to the outside air used for ventilation shall be screened for the control of insects and rodents. Screen doors shall be equipped with self-closing devices. H. The facility shall have a system for maintaining the residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7.8.2.44 NMAC - Rp, 7.8.2.45 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.44 A</p> <p>This is an uncorrected deficiency from a survey dated 08/11/15</p> <p>Based on record review and interview, the facility failed to ensure that the gas furnace heater was inspected annually. This deficient practice has the potential for all 14 (R #s 1-14) resident's identified on the resident census list provided by the</p>	{A044}	<p><i>we have developed an inspections form that lists all of the equipment/machinery that requires inspection. The form lists when each piece of equipment needs to be inspected. This form will be posted in the office as a reminder of the inspection dates. The house manager will ensure that inspections are performed when listed on the form.</i></p>	8/1/17

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NAME OF PROVIDER OR SUPPLIER  
**SIERRA SPRINGS ASSISTED LIVING**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**503 LOS LENTES ROAD NE  
LOS LUNAS, NM 87031**

(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 044}	Continued From page 20  Administrator on 02/23/17, to be at risk of harm or death if the furnace is not inspected on an annual basis and either quits working or develops a gas leak. The findings are:  A. Record review of heating ventilation and air conditioning (HVAC) inspection checklist prepared by [Name of Inspector and Facility] revealed that the gas furnace was last inspected on 09/01/15.  B. On 02/23/16 at 2:35 pm, during interview with Administrator, she confirmed that the gas furnace heater had been inspected on 09/01/15.	{A 044}		
{A 060}	7 NMAC 8.2.60 Fire Clearance 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	{A 060}	<i>In order to correct the violation of not ensuring that the Fire Marshal conducted the annual fire inspection the administrator will contact the Fire Marshal and ask that a fire inspection would be conducted as soon as possible. In order to ensure ongoing compliance the fire inspection is listed on the inspection</i>	

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NAME OF PROVIDER OR SUPPLIER  <b>SIERRA SPRINGS ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 LOS LENTES ROAD NE LOS LUNAS, NM 87031</b>
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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 060}	<p>Continued From page 21</p> <p>by: 7.8.2.60 B</p> <p>This is an uncorrected deficiency from a survey dated 08/11/15</p> <p>Based on record review and interview the facility failed to ensure that fire inspections were conducted annually by the Fire Marshal's office or a local fire prevention authority. This deficient practice has the potential to affect all 14 (R #s 1-14) residents identified on the census provided by the Administrator on 02/23/17 as well as staff and visitors. If the facility is not conducting annual fire inspections and ensuring the facility is safe in the event of a fire then all 14 residents are at risk for fire and smoke related injuries or death if a fire occurs. The findings are:</p> <p>A. Record of the facility Fire Inspection records revealed that the last Annual Fire and Life-Safety Inspection was completed on 11/02/15.</p> <p>B. On 02/23/17 at 2:40 pm, during an interview with Administrator, she confirmed that the last Annual Fire and Life-Safety Inspection was on 11/02/15.</p>	{A 060}	<p><i>form. The Home manager will be in charge of contacting the Fire Marshal every August to conduct a fire inspection.</i></p>	8/11/17
{A 062}	<p>7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System</p> <p>AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Facilities with nine (9) or more residents shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. [7.8.2.62 NMAC - Rp, 7.8.2.61 NMAC, 01/15/2010]</p>	{A 062}	<p><i>- in order to correct the violation of not having the kitchen's range fire hood inspected every 6 months an inspection will be scheduled by the</i></p>	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>2039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R-C <b>02/23/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SIERRA SPRINGS ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 LOS LENTES ROAD NE LOS LUNAS, NM 87031</b>
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[A062]	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.62</p> <p>This is an uncorrected deficiency from a survey dated 08/11/15</p> <p>Reference NFPA 96, 1998 Edition</p> <p>8-2* Inspection. An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons.</p> <p>8-2.1 All actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire-actuated dampers, shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. In addition to these requirements, the specific inspection requirements of the applicable NFPA standard shall also be followed.</p> <p>Based on record review and interview, the facility failed to ensure the kitchen's range fire hood suppression system was inspected at least every six months (semi-annual) as required by The National Fire Protection Association (NFPA) 96 (Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations). Not inspecting the range hood at least every six months could result in the fire suppression</p>	[A062]	<p>house manager with a local licensed inspector. In order to ensure compliance the hood inspection is listed on the inspections form that is posted in the office. The house manager will insure that the kitchen's range fire hood will be inspected according to the equipment inspection form.</p>	8/11/17
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Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>2039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>02/23/2017</b>
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**SIERRA SPRINGS ASSISTED LIVING**

**503 LOS LENTES ROAD NE  
LOS LUNAS, NM 87031**

(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 062}	<p>Continued From page 23</p> <p>system not activating in the event of fire, which presents a risk of potential harm to all 14 (R #s 1-14) residents identified on the resident census list provided by the Administrator on 02/23/17. The findings are:</p> <p>A. Record review of the range hood inspections revealed that the last inspection was performed on 08/20/15.</p> <p>B. On 02/23/17 at 2:50 pm, during interview with the Administrator, she confirmed that the range hood had not been inspected since 08/20/15.</p>	{A 062}		