STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5873	A. BUILDING: _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OF ALAMOGORDO II (THE)	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 as a result of a Full-Onsite/Complaint survey completed on 08/02/18 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake NM00030426 was unsubstantiated with no deficiencies cited.	A 000		
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	Continued From page 1 (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.17 A B C (8, 10, & 12) Based on record review and interview, the facility failed to ensure for 4 (DCS #s 1-4) of 4 (DCS #s 1-4) Direct Care Staff whose training files were reviewed for compliance received the following required orientation/annual trainings: 1. Orientation for new employees (DCS #s 1, 2 and 3). 2. Smoking policy (DCS #4). 3. Emergency procedures (DCS #4). 4. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist with ISPs (DCS #4). This deficient practice has the potential for all residents to be at risk of harm or injury if staff have not received training on the proper methods of providing care and services. The findings are: A. Record review of DCS #1's (date of hire: 06/25/18) staff file revealed, it was missing documentation for new employee orientation	A 017		

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A 017	Continued From page 2 training. B. Record review of DCS #2's (date of hire: 01/26/18) staff file revealed, it was missing documentation for new employee orientation training. C. Record review of DCS #3's (date of hire: 12/12/17) staff file revealed, it was missing documentation for new employee orientation training. D. Record review of DCS #4's (date of hire: 02/26/13) staff file revealed, it was missing documentation of annual trainings for: 1. Smoking policy for staff, residents and visitors; 2. Emergency procedures; 3. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist with ISPs. E. On 08/02/18 at 11:15 am, during an interview with the Administrator, she confirmed that documentation of new employee orientation trainings were missing from DCS #s 1-3 files, and annual trainings for DCS #4 were not completed for the past year.	A 017		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable	A 020		

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A 020	Continued From page 3 to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the	A 020		

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A 020	Continued From page 4	A 020		

resident's safety and welfare;
(ii) the resident's needs cannot safely be met in the facility; or
(iii) the safety and health of other residents and staff in the facility are endangered;
(13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and
(14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents.
B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following:
(1) ventilator dependency;
(2) pressure sores and decubitus ulcers (stage III or IV);
(3) intravenous therapy or injections;
(4) any condition requiring either physical or chemical restraints;
(5) nasogastric tubes;
(6) tracheostomy care;
(7) residents that present an imminent physical threat or danger to self or others;
(8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP;
(9) residents with a diagnosis that requires isolation techniques;

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A 020	Continued From page 5 (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident,	A 020		

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A 020	Continued From page 6 the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.20 A. (14) Based on observation, record review, and interview, the facility failed to ensure for 2 (R #s 2 and 3) of 4 (R #s 1-4) residents whose admission agreements were reviewed for compliance that the facility: 1. Is operating as a Memory Care Unit (MCU) and the specialized training the staff receive, is stated in the Admissions Agreement; 2. Had an Admission Agreement on record at the facility stating services to be provided or cost of services.	A 020		

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This deficient practice has the potential for residents residing in the MCU to be at risk of harm if they do not receive the higher level of care and services needed if:

1. Residents/families are unaware that the residents are residing in a specialized MCU and are unaware of what specialized trainings the staff are required to have;

3. There is not an Admission Agreement stating services to be provided or cost of services.

The findings are:

A. On 07/30/18 at 11:40 am, during observation and tour of the facility, the facility was observed to be a secured environment with locked doors that restrict access to the public way for residents who require a secured MCU.

B. Record review of R #2's Admission Agreement (dated 02/02/17) revealed, the following:

1. The resident was admitted to the memory care facility and the admission agreement was from a sister facility that is not a memory care facility (admission to memory care facility 04/18/17 with no new agreement completed).

2. There was no mention of the facility operating as a memory care unit in the narrative or the admission agreement;

C. Record review of R #3's chart revealed, no Admission Agreement that included cost of services was available for review.

D. On 07/31/18 at 11:30 am, during an interview with the Administrator, she confirmed that:

1. The Admission Agreement for R #2 stated the facility is not operating as a MCU, a new admission agreement had not been completed

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A 020	Continued From page 8 when the resident transferred from the sister facility stating this facility is a MCU, and that staff have specialized training for dementia; 2. The Admission Agreement stating services to be provided and cost of services for R #3 could not be found.	A 020		
A 061	7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: A. Fire alarm system. Facilities with four (4) or more residents shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction. B. Smoke and heat detection. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining and living room(s) must also be provided with smoke detectors. (1) Detectors shall be powered by the house electrical service and have battery back up. (2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room. (3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service. [7.8.2.61 NMAC - Rp, 7.8.2.60 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced	A 061		

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A 061	Continued From page 9 by: 7.8.2.61 A NFPA (National Fire Prevention Association) 101, 2012 Edition 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 11/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of	A 061		

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30 seconds and a diagnostic routine.
(3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator.
(4) A visual inspection shall be performed at intervals not exceeding 30 days.
(5) Functional testing shall be conducted annually for a minimum of 11/2 hours.
(6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 11/2-hour test.
(7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.

7.10.9 Testing and Maintenance.
7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days or shall be periodically monitored in accordance with 7.9.3.1.3.
7.10.9.2 Testing. Exit signs connected to, or provided with, a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3.

Based on observation, record review and interview, the facility failed to ensure that:
1. All emergency lighting was in working order.
2. The fire alarm was tested monthly.

This deficient practice has the potential for all 13 (R #s 1-13) residents identified on the census provided by the Administrator on 07/30/18, to be at risk of injury or death if residents and staff do not know there is a fire, if the alarm system doesn't work properly and if the emergency lights do not work during a power outage. The findings

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A 061	Continued From page 11 are: Findings on the emergency lighting system A. On 06/13/17 at 3:10 pm, during an observation of a power outage, four emergency lights, near rooms 12, 17, 20, and 24 were observed to not be working. B. On 06/13/17 at 3:10 pm, during an interview, the Head of Maintenance confirmed, that the four emergency lights near rooms 12, 17, 20, and room 24 were not working. Findings on monthly testing of the fire alarm C. Record review of facility's fire alarm testing records revealed, the last monthly test was 03/01/18. D. On 08/02/18 at 11:05 am, during an interview with the Administrator, she confirmed that the fire alarm had not been tested since 03/01/18.	A 061		
A 062	7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System 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] This REQUIREMENT is not met as evidenced	A 062		

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A 062	Continued From page 12 by: Refer to 7.8.2.62 which refers to NFPA (National Fire Prevention Association) 13 NFPA 13.6.2.7.1 Plates, escutcheons, or other devices used to cover annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. Based on observation and interview, the facility failed to maintain the escutcheon plates (shield that surrounds) on the sprinkler heads in 3 locations in the facility. This deficient practice presents a risk that the sprinkler system may not function properly in the event of a fire emergency and leaves a path for smoke and fire to pass through, which could result in harm to all 13 (R #s 1 through 13) residents on the Resident Census List, provided by the Administrator on 07/30/18, and all occupants of the building in the event of a fire. The findings are: A. On 08/02/18 at 1:39 pm, during observation and tour of the facility with the Head of maintenance, the escutcheon plates around the sprinkler head in the linen closet was missing, in room 24 was not sealing the annular space (opening) around the sprinkler head, and in the bath/shower room it was not sealed. B. On 08/02/18 at 1:39 pm, during an interview with the Head of maintenance, he confirmed the escutcheon plates around the sprinkler head in the linen closet was missing, in room 24 was not sealed, and in the bath/shower room it was not sealed, leaving an opening around the annular space (opening) around the sprinkler head into the attic and could possibly impair the sprinkler from operating properly.	A 062		

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A 065	Continued From page 13	A 065		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 A B (5) Based on record review and interview, the facility failed to: 1. Conduct fire drills each 8 hours of the day (day, evening, night) per quarter. 2. Failed to employ the use of the fire alarm system. 3. Have the evacuation time in total minutes. This deficient practice has the potential for all 13	A 065		

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	5873	A. BUILDING: _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OF ALAMOGORDO II (THE)	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

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A 065	Continued From page 14 (R #s 1-13) residents identified on the census provided by the Administrator on 07/30/18 and all occupants of the building, to be at risk of harm and/or death if the staff are not prepared to carry out a safe evacuation of residents and notification of the fire department in the event of a fire. The findings are: A. Record review of the facility's fire drill record book revealed: 1. From 10/01/17 to 12/31/17 and from 02/01/18 to 06/30/18 there were no fire drills conducted during the night from 11:00 pm to 7:00 am. 2. On the drills conducted on 08/31/17, 09/25/17, 11/30/17, 03/30/18, 05/30/18, 04/30/18, 06/29/18, and 07/27/18 the drills did not employee the use of the fire alarm system. 3. There were no evacuation times in total minutes on any of the fire drill records. B. On 08/02/18 at 11:05 am, during an interview with the Administrator, she confirmed that the fire drills were not being conducted during the night and that the fire alarm was not used due to upsetting the residents. She also confirmed the evacuation time in total minutes was not documented.	A 065		
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following	A 068		

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A 068	Continued From page 15 definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live.	A 068		

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A 068	Continued From page 16 (8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and	A 068		

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A 068	Continued From page 17 (g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall	A 068		

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A 068	Continued From page 18 support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified.	A 068		

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A 068	Continued From page 19 E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.68 B (1) (2) Based on record review and interview, the facility failed to ensure that 1 (DCS #4) of 1 (DCS #4) Direct Care Staff that had worked there for at least 1 year had the following: 1. An additional 6 hours of hospice specific training annually. 2. Documentation of an ongoing employee psychological support program for end of life care issues. This deficient practice has the potential for residents receiving hospice services to not receive the higher level of care and services they	A 068		

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A 068	Continued From page 20 need. The findings are: A. Record review of DCS #4's (date of hire: 02/26/13) staff file revealed, missing documentation for 6-hours of hospice training to include one (1) hour specific to the hospice resident's ISP (Individual Service Plan) and there was no documentation of an employee psychological support program for end of life care issues. B. On 08/01/18 at 10:45 am, during an interview with the Administrator, she confirmed that there is no documentation for the required six (6) hours of hospice specific trainings for DCS #4 and the facility had no documentation of their employee psychological support program for end of life care issues.	A 068		
A 069	7 NMAC 8.2.69 Memory Care Units MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions: The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply. (1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer ' s gets progressively worse and is fatal. (2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require	A 069		

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A 069	Continued From page 21	A 069		

additional care and services.
(3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain.
(4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program.
(5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit.
B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process.
(1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services.
(2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside health care provider.
C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information.
D. Individual service plan (ISP). An assisted living

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A 069	Continued From page 22	A 069		

facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria:
(1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs;
(2) medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals:
(a) a physician;
(b) a physician extender (PA or NP);
(c) a licensed nurse (RN or LPN);
(d) the resident if their PCP has approved it;
(e) family or family designee; and
(f) any other individual in accordance with applicable state and local laws.
E. Assessments and reevaluations.
(1) An assessment shall be completed by a registered nurse or a physician extender within fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5) days after admission.
(a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission.
(b) The pre-admission assessment shall include

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written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit.
(c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted.
(2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident ' s stay in the assisted living facility memory care unit is still appropriate.
F. Documentation in the resident ' s record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record:
(1) the physician ' s diagnosis for admission to a secure environment or a memory care unit;
(2) the pre-admission assessment; and
(3) the re-evaluation(s).
G. Secured environment.
(1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to:
(a) double alarm systems;
(b) gates connected to the fire alarm; and
(c) tab alarms for residents at risk for elopement.

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A 069	Continued From page 24 (2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents. (a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident ' s legal representative, if applicable and prior to the resident ' s admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for. (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff	A 069		

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A 069	Continued From page 25 provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.69 C Based on record review and interview, the facility failed to ensure for 1 (DCS #4) of 1 (DCS #4) Direct Care Staff employed for over one year completed the required additional 12 hours of annual dementia (A group of thinking and social symptoms that interferes with daily functioning) specific training. This deficient practice has the potential for residents residing in the Memory Care Unit (MCU) to be at risk of not receiving the individual (physical, mental, social) care and services residents with Dementia (a decline in memory or other thinking skills) require because the DCS have not completed the required annual specialized dementia training. The findings are: A. Record review of DCS #4's (date of hire: 02/26/13) staff file revealed, documentation that DCS #4 received only 6 of the twelve (12) hours of required annual Dementia training. B. On 08/01/18 at 10:45 am, during an interview with the Administrator, she confirmed that DCS #4 did not complete the 12 hours of required annual Dementia training.	A 069		