

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------

(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 result of a Full-Onsite survey completed on 05/26/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. [REDACTED]	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; (10) emergency procedures;	A 017		

Division of Health Improvement

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

Larry Mickwitz

TITLE

Owner

(X6) DATE

1/30/17

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/26/2016	
NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201		
(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 017	<p>Continued From page 1</p> <p>(11) medication assistance, including the certificate of training for staff that assist with medication delivery; and</p> <p>(12) the proper way to implement a resident ISP for staff that assist with ISPs.</p> <p>D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.17 C (11)</p> <p>Based on record review and interview, the facility failed to ensure that 5 (DCS #s 1-5) of 5 (DCS #s 1-5) Direct Care Staff who were reviewed for staff training had received their annual re-certification training for Assisting with Medication Delivery. This deficient practice increases the potential to negatively impact the health, safety, and welfare of all residents by staff not knowing the proper methods of assisting with their medication(s). The finding are:</p> <p>A. Record review of DCS #1's employee file revealed that DCS #1 did not have evidence of re-certification for Assisting with Medication Delivery training.</p> <p>B. Record review of DCS #2's employee file revealed that DCS #2 did not have evidence of re-certification for Assisting with Medication Delivery training.</p> <p>C. Record review of DCS #3's employee file</p>	A 017	<p><i>DCS #1 was recertified for Assisting with Medication Delivery.</i></p> <p><i>DCS #2 was recertified for Assisting with Medication Delivery.</i></p>	<p><i>11/9/16</i></p> <p><i>11/9/16</i></p>

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201		
(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 017	Continued From page 2 revealed that DCS #3 did not have evidence of re-certification for Assisting with Medication Delivery training. D. Record review of DCS #4's employee file revealed that DCS #4 did not have evidence of re-certification for Assisting with Medication Delivery training. E. Record review of DCS #5's employee file revealed that DCS #5 did not have evidence of re-certification for Assisting with Medication Delivery training. F. On 05/26/16 at 9:35 am, during interview with the administrator, she confirmed that DCS #s 1-5 all had expired Assisting with Medication Delivery certificates and they have not yet completed the re-certification for their trainings.	A 017	DCS #3 was recertified for Assisting with Medication Delivery. DCS #4 was recertified for Assisting with Medication Delivery. DCS #5 was recertified for Assisting with Medication Delivery.	11/9/16 11/9/16 11/9/16
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident's surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer,	A 020	To ensure future compliance we have elected one office personnel to perform yearly chart reviews on employees so these items are not missed.	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------

(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 020	<p>Continued From page 3</p> <p>voluntary or involuntary discharge;</p> <p>(6) information to formulate advance directives;</p> <p>(7) a written description of the legal rights of the residents translated into another language, if necessary;</p> <p>(8) the facility's staffing ratio;</p> <p>(9) written authorization for staff to assist with medications;</p> <p>(10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC;</p> <p>(11) the facility ' s bed hold policy; and</p> <p>(12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances:</p> <p>(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;</p> <p>(b) the resident has failed to pay for a stay at the facility as defined in the admission agreement;</p> <p>(c) the facility ceases to operate or is no longer able to provide services to the resident;</p> <p>(d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility;</p> <p>(e) termination without prior notice is permitted in emergency situations for the following reasons:</p> <p>(i) the transfer or discharge is necessary for the resident's safety and welfare;</p> <p>(ii) the resident's needs cannot safely be met in the facility; or</p> <p>(iii) the safety and health of other residents and staff in the facility are endangered;</p> <p>(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</p>	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------

(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 020	<p>Continued From page 4</p> <p>executed whenever services, costs or other material terms are changed; and</p> <p>(14) facilities representing their services as "specialized" must disclose evidence of staff specialty training to prospective residents.</p> <p>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:</p> <ul style="list-style-type: none"> (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). <p>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</p>	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------

(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 020	<p>Continued From page 5</p> <p>facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements.</p> <p>(1) Convene a team, comprised of:</p> <p>(a) the facility administrator and a facility health care professional if desired;</p> <p>(b) the resident or resident ' s surrogate decision maker; and</p> <p>(c) the hospice or home health clinician.</p> <p>(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:</p> <p>(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;</p> <p>(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);</p> <p>(c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and</p> <p>(d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility.</p> <p>(3) The team recommendation shall be maintained on site in the resident ' s file.</p> <p>(4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident.</p> <p>D. Coordination of care.</p> <p>(1) Assisted living facilities shall have evidence of</p>	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016	
NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201		
(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 020	<p>Continued From page 6</p> <p>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.</p> <p>(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.</p> <p>[7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (3) (5) (8) (9) (10) (12) (14)</p> <p>Based on record review and interview, the facility failed to ensure that admission agreements were complete for 1 (R #1) of 8 (R #s 1- 8) residents and 2 (FR #s 9 and 10) of 2 (FR #s 9 and 10) former residents, whose charts were reviewed for completeness of admission agreements. This deficient practice has the potential for residents to be at risk of not understanding or knowing all aspects of the facilities procedures, rules and regulations which includes possibly not knowing what services will be provided. The findings are:</p> <p>A. Record review of R # 1's, and FR # 9's and 10's, admission agreements revealed that there was no documentation relating to:</p> <ol style="list-style-type: none"> 1. Facility rules. 2. Refund provision in case of death. 3. Facility staffing ratio. 4. Written authorization for staff to assist with medications. 	A 020	<p>The Admission agreement has been updated to include all needed information. Future admissions will all be done on updated forms to ensure compliance.</p>	1/23/17

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	-----------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------

(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 020	Continued From page 7 5. Notification of rights and responsibilities for incident reporting. 6. Admissions and discharge agreements stating reasons for termination. 7. Facility disclosing specialized training for Residents. B. On 05/26/16 at 2:47 pm, during interview, the administrator confirmed the incomplete admission agreements and stated that she knows that she wanted to change the admission agreements.	A 020	<i>Admission agreement now has documentation relating to facility rules, refund in case of death, staffing ratio, authorization for meds, notification of rights & responsibilities for incident reporting, Admission & discharge agreements for incident terminations, and</i>	
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,	A 025	<i>Resident evaluation information had been filed in on an Admission Nursing Assessment form. Form has since been updated and is now in place to be used to evaluate all prospective residents.</i>	<i>12/13/16</i>

AD20 continued - facility disclosing specialized training for Residents. The new admission agreements are in place for all future admissions. The new admission agreement will be provided to current residents / family for signatures and a copy provided to them. The process to have existing residents Admission Agreements updated will start 3/4/17. After the administrator has completed an admission, the office manager will ensure all paperwork has been completed.

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	----------------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
-----------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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 025	<p>Continued From page 8</p> <p>etc;</p> <p>(4) vision;</p> <p>(5) physical functioning and skeletal problems;</p> <p>(6) incontinence of bowel/bladder;</p> <p>(7) psychosocial well-being;</p> <p>(8) mood and behavior;</p> <p>(9) activity interests;</p> <p>(10) diagnoses;</p> <p>(11) health conditions;</p> <p>(12) nutritional status;</p> <p>(13) oral or dental status;</p> <p>(14) skin conditions;</p> <p>(15) medication use and level of assistance needed with medications;</p> <p>(16) special treatments and procedures or special medical needs such as hospice; and</p> <p>(17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc.</p> <p>D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually.</p> <p>E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs.</p> <p>[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>	A 025	<p>The Evaluation form includes Activities of daily living, cognitive abilities, communication and hearing, vision, physical functioning & skeletal problems, bowel & bladder, psychosocial well being, mood & behavior, activity interests, diagnoses, health conditions, nutritional status, oral or dental status, skin conditions, medication use & level of assistance needed, special treatments & procedures or special medical needs such as hospice, and safety needs / high risk behaviors, history of falls, agitation, wandering, fire safety issues.</p>	
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201		
(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 025	Continued From page 9 Based on record review and interview the facility failed to ensure that for 1 (R #1) of 1 (R #1) residents and 2 (FR #s 9 and 10) of 2 (FR #s 9 and 10) former residents evaluations were completed with documentation of 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; (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. This deficient practice has the potential for the residents to not receive the appropriate care and assistance they need as changes in their health status occurs due to the evaluations not being completed and reviewed as required. The findings are: A. Record review of the chart for R #1 revealed she was admitted on 03/23/16 and there was no facility evaluation in her chart.	A 025	This form has been included in all prospective residents packet. It will be completed within 15 days prior to admission. The process to get those residents who did not have an evaluation in their chart has already been started and should be completed within the next week. The administrator will complete the Evaluation prior to admission. The office manager will also ensure the Evaluation is complete when we review the	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	----------------------------------------------------------------	------------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER
HEARTFELT MANOR INCORPORATE

STREET ADDRESS, CITY, STATE, ZIP CODE
**2210 EAST PINE LODGE ROAD
ROSWELL, NM 88201**

(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 025	<p>Continued From page 10</p> <p>B. Record review of FR #9's facility file revealed he was admitted on 01/14/16 and there was no facility evaluation in his chart.</p> <p>C. Record review of FR #10's facility file revealed she was admitted on 11/21/14 and there was no facility evaluation in her chart.</p> <p>D. On 05/26/16 at 2:00 pm, in an interview, the Administrator confirmed the Evaluations for R #1, and FR #9, and FR #10 had not been completed.</p>	A 025	<p><i>form to use whether we will be able to accept the resident. If so, the office manager will ensure this is included in the Residents Chart.</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> <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>	A 026		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------

(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 026	<p>Continued From page 11</p> <p>(4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.26 A. (1) Based on record review and interview the facility failed to ensure that for 1 (R #1) of 1 (R #1) residents and 2 (FR #s 9 and 10) of 2 (FR #s 9 and 10) former residents whose Individual Service Plans (ISPs) were reviewed for complete documentation included the following: (1) areas of need as identified in the resident evaluation and through staff observation; (2) services that are provided by the facility as well as the services to be provided by other agencies; (3) reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender; (4) 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; (5) a description of identified needs as noted in</p>	A 026	<p><i>New ISP forms have been generated and completed for each resident.</i></p> <p><i>This updated form has been made part of the Admission Packet and will be completed upon admission.</i></p>	<p><i>11/1/16</i></p>
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	----------------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
-----------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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 026	<p>Continued From page 12</p> <p>the resident evaluation;</p> <p>(6) a written description of all services to be provided;</p> <p>(7) who will provide the services;</p> <p>(8) when or how often the services will be provided;</p> <p>(9) how the services will be provided;</p> <p>(10) where the services will be provided;</p> <p>(11) expected goals and outcomes of the services;</p> <p>(12) documentation of the facility's determination that it is able to meet the needs of the resident;</p> <p>(13) the level of assistance that the resident will require with activities of daily living and with medications;</p> <p>(14) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and</p> <p>This deficient practice has the potential for the residents to not receive the appropriate care and assistance they need as changes in their health status occurs due to ISPs not being completed and reviewed as required. The findings are:</p> <p>A. Record review of the chart for R #1 revealed she was admitted on 03/23/16 and there was no facility ISP in her chart.</p> <p>B. Record review of FR #9's facility file revealed he was admitted on 01/14/16 and there was no facility ISP in his chart.</p> <p>C. Record review of FR #10's facility file revealed she was admitted on 11/21/14 and there was no facility ISP in her chart.</p> <p>D. On 05/26/16 at 2:00 pm, in an interview, the Administrator confirmed the ISPs for R #1, and FR #9, and FR #10 had not been completed.</p>	A 026	<p>The ISP includes a description of identified needs as noted in evaluation, written description of services to be provided, who will provide the services, when or how often the services are provided, how the services will be provided, where the services will be provided, expected goals & outcomes of the services, documentation of the facility's determination that it is able to meet the needs of the resident, the level of assistance that the resident will require with activities of daily</p>	
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	----------------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER
HEARTFELT MANOR INCORPORATE

STREET ADDRESS, CITY, STATE, ZIP CODE
**2210 EAST PINE LODGE ROAD
ROSWELL, NM 88201**

(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 034	Continued From page 13	A 034		
A 034	<p>7 NMAC 8.2.34 Custodial Drug Permits</p> <p>CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to 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.</p> <p>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.</p> <p>(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.</p> <p>(2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms.</p> <p>(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.</p> <p>(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.</p> <p>(5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate.</p>	A 034	<p>living and medications, a crisis prevention intervention plan when indicated by diagnosis or behavior ↓ current orders for all medications, including those authorized for PRN usage. Once the ILSP is completed, it will be presented to the PRN for review. Current residents who may not have had an ILSP in their chart now do. The office manager & PRN will ensure these are in charts + reviewed/ revised at least every 6 months.</p>	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201		
(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 034	Continued From page 14 (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to	A 034		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------

(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 034	<p>Continued From page 15</p> <p>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 (1) (3)</p> <p>Based on observation and interview, the facility failed to ensure the health and safety for all 8 (R #'s 1 - 8) residents as listed on the resident census, provided by the administrator on 05/23/16, currently residing at the facility by:</p> <ol style="list-style-type: none"> 1. Not having a lock on the medication refrigerator. 2. Storing insulin with food in the kitchen refrigerator. <p>This deficient practice has the potential for residents to be harmed if they were to have access to the unsecured medications. If food and</p>	A 034		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------------	----------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER
HEARTFELT MANOR INCORPORATE

STREET ADDRESS, CITY, STATE, ZIP CODE
**2210 EAST PINE LODGE ROAD
ROSWELL, NM 88201**

(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 034	<p>Continued From page 16</p> <p>medication were to become contaminated then residents may become ill. The findings are:</p> <p>A. On 05/25/16 at 3:00 pm, during observation 1 vile of Novolin R (Regular Human Insulin Injection) 100 units was observed to be stored in the kitchen refrigerator.</p> <p>B. On 05/25/16 at 3:05 pm, during observation and interview, administrator and Staff (S) #1, confirmed that there was one vile of insulin stored in the kitchen's food refrigerator. S #1, removed the Novolin from the food refrigerator and placed the Novolin in a refrigerator located in the pantry meant for medications which did not have a lock on it. The Administrator and S #1, confirmed that the medication refrigerator did not have a lock on it. The administrator stated that they keep the resident's insulin in the fridge in case she needs it.</p>	A 034	<p>Novolin R was removed from kitchen refrigerator immediately. The medication refrigerator in the pantry has had a lock added.</p>	<p>5/25/16</p> <p>5/29/16</p>
A 036	<p>7 NMAC 8.2.36 Nutrition</p> <p>NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the "recommended daily dietary allowance" of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the "2005 USDA dietary guidelines for Americans." Vending machines shall not be considered a source of snacks.</p> <p>A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements.</p>	A 036	<p>This is now checked every shift to ensure the lock is secured and not accessible to residents. The medication aide on duty is responsible to make sure the lock is secure.</p>	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	----------------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
-----------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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 036	<p>Continued From page 17</p> <p>(1) Meal service. The facility shall:</p> <ul style="list-style-type: none"> (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident's physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident's PCP within forty-eight (48) hours if a resident consistently refuses to eat. <p>(2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes:</p> <ul style="list-style-type: none"> (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; 	A 036	<p><i>When medications are present in the refrigerator. A form will be made within the coming week that each medication aide will be required to initial at the change of each shift when the med keys are passed to that person. Initialing the form each shift will verify med. aide has checked to ensure the lock is secure when medications are present.</i></p>	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------

(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 036	<p>Continued From page 18</p> <p>(d) appropriate personal hygiene; and (e) infectious and communicable disease control.</p> <p>B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days.</p> <p>C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC.</p> <p>(1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair.</p> <p>(2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing,</p>	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	----------------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
-----------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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 036	<p>Continued From page 19</p> <p>rinsing and sanitizing.</p> <p>(b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff.</p> <p>(c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented.</p> <p>(d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection.</p> <p>(3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels.</p> <p>(4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner.</p> <p>(5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority.</p> <p>D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC.</p> <p>(1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents.</p>	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201		
(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 036	Continued From page 20 (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin.	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------

(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 036	<p>Continued From page 21</p> <p>(8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts.</p> <p>E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk.</p> <p>F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.36 D. (5)</p> <p>Based on observation and interview the facility failed to ensure the health and safety of the facility's 8 (R #1 - 8) residents identified on the</p>	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------

(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 036	<p>Continued From page 22</p> <p>resident census list form provided by the administrator on 05/23/16, by storing poison in the storage area used for the residents' food storage. This deficient practice has the potential for the food for the residents to be contaminated with the poison.</p> <p>A. On 05/23/16 at 3:03 pm, two cans of automotive starting fluid were observed stored in the food storage area with the food for residents.</p> <p>B. On 05/23/16 at 3:03 pm, the Administrator confirmed the two cans of automotive starting fluid were stored in the food storage area with the food for residents.</p>	A 036	<p><i>The two cans of automotive starting fluid was removed immediately from the food storage area.</i></p>	<p><i>5/23/16</i></p>
A 042	<p>7 NMAC 8.2.42 Maintenance of Building and Grounds</p> <p>MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas:</p> <p>A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard.</p> <p>B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility</p>	A 042	<p><i>The food storage areas are checked each shift to ensure there are no chemical substances of any kind in this area.</i></p>	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	-----------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201
------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------

(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 042	<p>Continued From page 23</p> <p>failed to ensure the safety of the facility's 8 (R #1-8) residents identified on the resident census list provided by the administrator on 05/23/16, by not maintaining an outdoor light fixture by an approved exit to the facility. This deficient practice could lead to a resident being shocked by an exposed electrical current. The findings are:</p> <p>A. On 05/26/16 at 2:00 pm, during a tour of the facility with the Administrator, an outdoor light by the approved exit #2 was observed to not have a bulb, cover, and had a hole on the side of the housing of the fixture exposing electrical circuitry within reach of residents and all occupants of the building and grounds.</p> <p>B. On 05/26/16 at 2:00 pm, the Administrator confirmed the outdoor light by the West hallway approved exit #2 did not have a bulb or cover and had a hole on the side of the housing of the fixture exposing electrical circuitry within reach of residents and all occupants of the building and grounds.</p>	A 042	<p>The outdoor light at approved exit #2 has been repaired with a new bulb and cover.</p> <p>A walkaround of the facility is performed daily to ensure the grounds are kept up and in a safe and working order. This will either be performed by the office</p>	5/26/16
A 052	<p>7 NMAC 8.2.52 Corridors</p> <p>CORRIDORS:</p> <p>A. Corridors in an existing building shall have a minimum width of thirty-six (36) inches. Corridors in newly constructed facilities shall have a minimum width of forty-four (44) inches.</p> <p>B. Corridors shall have a clear ceiling height of not less than seven (7) feet measured to the lowest projection from the ceiling.</p> <p>C. Corridors shall be maintained clear and free of obstructions at all times.</p> <p>D. The floors of corridors and hallways shall be waterproof, greaseproof, smooth, slip-resistant</p>	A 052	<p>A walkaround of the facility is performed daily to ensure the grounds are kept up and in a safe and working order. This will either be performed by the office</p>	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
NAME OF PROVIDER OR SUPPLIER HEARTFELT MANOR INCORPORATE		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201		
(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 052	Continued From page 24 and durable. [7.8.2.52 NMAC - Rp, 7.8.2.53 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.52 A. & C. Based on observation and interview the facility failed to ensure the health and safety of the facility's 8 (R #1 through 8) residents identified on the resident census list provided by the Administrator on 05/23/16, by having furniture obstructing the paths to the two approved emergency exits from the building. This deficient practice could impede the evacuation of the residents in the event of an emergency. The findings are: A. On 05/26/16 at 10:36 am, during a tour of the facility, it was observed the facility's West hallway/corridor had a dresser against the south wall leaving only 31 inches of evacuation width to get to the West hallway approved Exit. It was also observed the facility's North hallway approved exit had an item of furniture leaving only 32 inches width to exit the building. B. On 05/26/16 at 10:36 am, during an interview with the Administrator, she confirmed the two exits were obstructed by the two items of furniture.	A 052	manager or administrator. A form will be made to initial when walkaround is complete. All issues needed addressed will be brought to administrators attention immediately, if walkaround is done by office manager. Furniture that was obstructing the path of evacuation in the corridors was moved immediately. 5/23/16 Nothing will be placed in path of approved exits that may hinder evacuations. This	
A 064	7 NMAC 8.2.64 Fire Safety Equivalency System Rating FIRE SAFETY EQUIVALENCY SYSTEM RATING: In facilities without a sprinkler system;	A 064		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/26/2016
--------------------------------------------------	----------------------------------------------------------------	------------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER: HEARTFELT MANOR INCORPORATE
STREET ADDRESS, CITY, STATE, ZIP CODE: 2210 EAST PINE LODGE ROAD ROSWELL, NM 88201

(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 064	<p>Continued From page 25</p> <p>the fire safety equivalency system shall be conducted at least annually. The facility shall maintain an evacuation rating score of prompt when a fire safety equivalency system is required. [7.8.2.64 NMAC - Rp, 7.8.2.19 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to have a Fire Safety Equivalency System (FSES) survey for the facility's 8 (R #1 through 8) residents as identified by the resident census list provided by the Administrator on 05/23/16. This failed practice may lead to injury/death by fire of residents if there is not adequate staff to assist in the evacuation process. The findings are:</p> <p>A. Record review of the residents' (R #s 1-8) records revealed no FSES surveys for the Residents.</p> <p>B. On 05/26/16 at 2:00 pm, in an interview, the Administrator confirmed the facility does not have FSES surveys for the Residents.</p>	A 064	<p>will be monitored by the office manager or administrator. This will be observed when performing a walk around of the facility to ensure no walkways are obstructed.</p> <p>FSES surveys are now completed and on each residents charts. The surveys that were being used were obsolete so the new approved forms are in place and to be completed upon admission. The office manager will</p>	12/13/16
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------

AD64 continued - ensure FSES surveys are completed when there is a change in the number of residents or when there is a change in the residents condition. The office manager will then adjust schedules of employees as needed to ensure the safety of the residents by ensuring the facility has a prompt score on the survey.