

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5746	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2007
NAME OF PROVIDER OR SUPPLIER CRANE'S ROOST CARE HOME, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH PARK AVENUE AZTEC, NM 87410	
(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
A19	<p>7 NMAC 8.2.19 ADMISSIONS</p> <p>7.8.2.19 ADMISSIONS: No resident shall be admitted or retained who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. EXCEPTION: Maternity Shelters may accept residents below the age of eighteen (18).</p> <p>A. ADMISSION INTERVIEW. The Director of the facility or a designee responsible for admission and retention decisions, shall meet with the resident or the resident's agent or guardian, if the resident lacks decision-making capacity, and shall provide the resident with:</p> <ol style="list-style-type: none"> (1) The facility's program narrative. (2) The facility's rules. (3) The facility's admission agreement, including costs and charges, refund provision, and contract termination policies. (4) The facility's bed hold policy. (5) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (6) A written description of the legal rights of the residents translated into another language, if necessary. (7) The facility's staffing pattern. <p>B. RESTRICTIONS ON ADMISSIONS: Adult residential care facilities shall not admit or retain individuals requiring continuous nursing care. Conditions or circumstances that usually require continuous nursing care, may include, but not limited to the following:</p> <ol style="list-style-type: none"> (1) Ventilator dependency. (2) Pressure sores where skin loss penetrates beyond the skin, and into deeper tissue or bone, which are classified as Stage III or IV. (3) Intravenous therapy or injections directly into the vein. (4) Airborne infectious disease, in a communicable state, including tuberculosis, but 	A19	<p><i>AS PER INSPECTION SURVEY ON 9-11-07 - WE REALIZED THAT WE FAILED TO PROVIDE STATE LICENSING AUTHORITIES WITH ADMISSION RETENTION EXCEPTION PLAN - WE HAVE BEEN FOLLOWING INSTRUCTIONS GIVEN BY RES 1 + RES 2 PHYSICIANS.</i></p> <p><i>CRANE'S ROOST UNDER THE INSTRUCTIONS OF SURVEYOR HAD RES 1 RETESTED FOR SAID REASON FOR CONCERN OF UNIVERSAL INFECTION CONTROL.</i></p> <p><i>UPON GETTING RESULTS OF RES 1'S RESULTS BACK, WHICH SHOWED POSITIVE, WE SPOKE WITH RESIDENT + FAMILY TO INFORM THEM THAT RES 1 WOULD HAVE TO LEAVE OUR FACILITY. THE STATE LICENSING AUTHORITY RECOMMENDS THIS ACTION, BECAUSE WE ARE NOT A MEDICAL FACILITY. RES 2'S TEST RESULTS HAVE NOT COME BACK YET. IN THE RESULT OF A POSITIVE TEST RESULT, RES 2 WILL ALSO BE ASKED TO LEAVE OUR FACILITY.</i></p> <p><i>CRANE'S ROOST HAS PERFORMED ALL INSTRUCTIONS FOR CARE FOR THIER RESIDENTS, USING ALL PRECAUTIONS STATED BY PHYSICIANS, HOSPITALS + OTHER NURSING FACILITIES, WHEN RESIDENTS ARE ADMITTED OR RE-ADMITTED TO OUR HOME. WE FEEL VERY BAD IN THE RESULT OF THIS SITUATION. CRANE'S ROOST IS NOT A MEDICAL FACILITY, THEREFORE WE CAN ONLY GO BY THE ADVICE FROM THE FACILITIES WHICH ARE.</i></p> <p style="text-align: right;"><i>(CONTINUED)</i></p>

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Kelly P. Armstrong* TITLE: *Director* (X6) DATE: *9-21-07*

STATE FORM 021199 SEP 28 2007 F0RY11 If continuation sheet 1 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5746	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2007
NAME OF PROVIDER OR SUPPLIER CRANE'S ROOST CARE HOME, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH PARK AVENUE AZTEC, NM 87410		
(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
A19	Continued From Page 1 excluding infections such as the common cold. (5) Any condition requiring either physical or chemical restraints. (6) Nasogastric tubes / gastric tubes. (7) Tracheostomy care. (8) Individuals presenting an imminent physical threat or danger to self or others. (9) Individuals whose physician certifies that placement is no longer appropriate. C. ADMISSION/RETENTION EXCEPTIONS: 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 to remain in the facility, and the facility wishes to re-admit or retain the resident, the facility must: (1) Convene a team, comprised of: (a) The facility director. (b) The resident. (c) The resident's agent, guardian or surrogate decision maker. (d) The resident's advocate, such as the resident's case manager, Ombudsman, or social worker. (e) If the treating physician is unable to meet with the team, then consultation and recommendations via phone is acceptable. (f) Other appropriate health care professionals. (2) The team shall jointly determine if the resident should be admitted or allowed to remain in the facility. The team must approve a individual service plan that meets the specific needs of the resident. Such team approval must be in writing, signed and dated by all team members, must be maintained in the resident's record, and must: (a) Be based upon a individual service plan which identifies the resident's specific needs and addresses the manner that such needs will be met.	A19	To ENSURE that this situation does NOT occur AGAIN, CRANES ROOST will BE CHANGING OUR PHYSICIAN CARE PLANS to address this MATTER. RES 1's Family is trying to FIND BED IN SKILLED CARE AS SOON AS POSSIBLE. RES 2's RESULTS will BE REPORTED TO STATE AS SOON AS WE GET THEM. CRANES ROOST will NOTIFY STATE w/ ANY Admission/Retention EXCEPTIONS WITHIN THE 5 DAYS OF RETENTION TEAM APPROVAL	9-21-07

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5746	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2007
NAME OF PROVIDER OR SUPPLIER CRANE'S ROOST CARE HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH PARK AVENUE AZTEC, NM 87410		
(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	
A19	<p>Continued From Page 2</p> <p>(b) Ensure that the facility has and will maintain an evacuation rating of prompt or slow as determined by the Fire Safety Equivalency System (FSES).</p> <p>(c) Be based upon an assessment of the health, safety and well-being of the other facility residents.</p> <p>(d) Assess the impact that meeting the specific needs of the resident as set out in the individual service plan will have on the staff and on the other residents.</p> <p>(3) Notify the Licensing Authority within five (5) days of the completion of team approval. Such notification of team approval must be submitted in writing and include evidence of the team's consideration of items 7.8.2.19C2(a) through 7.8.2.19C2(d) above. [9-24-76, 7-11-86, 1-11-90, 4-7-97;7.8.2.19 NMAC - Rn. 7 NMAC 8.2.19, 8-31-00]</p> <p>This Requirement is not met as evidenced by: Refer to 7.8.2.19(C)(1) - Admission/Retention Exceptions</p> <p>Based on record review and interview, the facility failed to convene the required meeting for 2 facility residents (Resident's #1 and #2) currently admitted to the facility whose medical diagnosis requires a greater degree of care than the facility would normally provide. The findings are:</p> <p>A. On 9/11/07 at 9:30AM during review of the resident records, there was no documentation that a team meeting was held for Resident's #1 and #2 residing at the facility and whose diagnosis required universal precautions, additional training of staff and higher level of services received as a result of their diagnosis.</p>	A19			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5746	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2007
NAME OF PROVIDER OR SUPPLIER CRANE'S ROOST CARE HOME, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH PARK AVENUE AZTEC, NM 87410		
(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
A19	Continued From Page 3 B. On 9/11/07 at 11:15AM during an interview with the Administrator, she stated the problem would be corrected. Refer to 7.8.2.19(C)(3) - Notification of Admission/Retention Exception to Licensing Authority Based on record review and interview, the facility failed to submit documentation of comprehensive care plans to the licensing authority for admission/retention exceptions for 2 facility residents (Resident's #1 and #2) currently admitted to the facility whose medical diagnosis requires a greater degree of care than the facility would normally provide. The findings are: A. On 9/11/07 at 9:30AM during review of the resident records, there was no documentation that the licensing authority had received documentation of admission retention/exceptions for Resident's #1 and #2 whose diagnosis required universal precautions, additional training of staff and higher level of services received as a result of their diagnosis. B. On 9/11/07 at 11:15AM during an interview with the Administrator, she stated that she understood the seriousness of the matter.	A19		
A36	7 NMAC 8.2.36 MEDICATIONS 7.8.2.36 MEDICATIONS: Medications will be administered or staff assistance with medications provided and documented in accordance with state and federal laws.	A36	<i>A36 7NMAC 8.2.36. Medications HAD individual MEETINGS w/ ALL MED CERTIFIED STAFF. Spoke w/ THEM ON IMPORTANCE OF Following Assisting w/ MED PROCEDURES DIRECTORS COPIED Regulation 7 NMAC 8.2.36 CONTINUED -</i>	<i>9-18-07</i>

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5746	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2007
NAME OF PROVIDER OR SUPPLIER CRANE'S ROOST CARE HOME, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH PARK AVENUE AZTEC, NM 87410		
(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
A36	Continued From Page 4 A. Licensed health care professionals are responsible for the administration of medications. B. Facility staff may assist a resident with medications if written consent by the resident is given to the director of the facility or their designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with medications. All staff assisting with medications shall have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications. C. No medications, including over the counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order by the physician and entry into the resident's record. D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and side-effects. E. Medications prescribed for one resident shall not be used for another resident. F. The facility shall have a Medication Administration Record (MAR) documenting medications administered to residents, including over-the-counter medications. This documentation shall include: (1) Name of resident. (2) Date started. (3) Drug product name. (4) Dosage and form. (5) Strength of drug. (6) Route of administration (e.g. "by mouth"). (7) How often medication is to be taken. (8) Time taken and staff initials.	A36	OF Medications AND PLACED COPY ON WALL OF MED ROOM RIGHT ABOVE MEDICATION CART DIRECTOR DISCUSSED CURRENT VIOLATION W/ STAFF TO SHOW HOW UN-MARKED MEDS COULD BE REQURE BY ANOTHER MED CERTIFIED STAFF MEMBER CAUSING OVER DOSAGE TO RESIDENT	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5746	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2007
NAME OF PROVIDER OR SUPPLIER CRANE'S ROOST CARE HOME, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH PARK AVENUE AZTEC, NM 87410		
(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
A36	Continued From Page 5 (9) Dates when the medication is discontinued or changed. (10) The name and initials of all staff administering medications. G. Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting. H. PRN Medications: The use of PRN medications must be closely monitored and supervised by the facility and is based on one or more of the following conditions: (1) The resident is capable of determining when the medication is needed. (2) The resident's physician has provided detailed instructions to the pharmacy regarding the administering of the medication. The physicians instruction for a PRN medication shall include: (a) Symptoms that might indicate the use of the medication. (b) Exact dosage to be used. (c) The exact amount of medication to be used in a 24 hour period. (d) Directions as to what to do if the symptoms persist. (e) Possible interactions or side-effects that might occur. (f) Manufacturer's label information for directions if deemed adequate by the physician. I. The facility must report all medication errors to the physician. J. The facility shall develop and follow a written policy for unused, outdated, or recalled medications being kept in the facility. [7-1-64, 9-15-70, 7019074, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.36 NMAC - Rn, 7 NMAC 8.2.36, 8-31-00] This Requirement is not met as evidenced by: Refer to 7.8.2.36(F)(8) - The facility shall document medications administered to residents	A36		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5746	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2007
NAME OF PROVIDER OR SUPPLIER CRANE'S ROOST CARE HOME, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH PARK AVENUE AZTEC, NM 87410		
(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
A36	Continued From Page 6 using staff initials Based on record review and interview, the facility failed to properly document medications administered for 1 facility resident (Resident #3). The findings are: A. On 9/11/07 at 8:40AM during review of the MAR for resident #3, it was noted that the 9/11/07 dose of prescription Protonix, scheduled to be given at the 7:30AM, was not signed off as having been administered to the resident. B. On 9/11/07 at 8:41AM during interview of Staff #1, she stated that she had given the medication at 7:30AM but had "forgotten to sign" the MAR at the time the medication was administered.	A36		
A38	7 NMAC 8.2.38 FOOD MANAGEMENT 7.8.2.38 FOOD MANAGEMENT: Each facility must store, prepare, distribute and serve food under sanitary conditions and in accordance with the New Mexico Environment Department Food Service and Processor Regulations, if applicable. A. Each facility shall ensure a minimum of a three (3) day supply of perishable and a five (5) day supply of non-perishable or canned food is provided for the residents. B. All milk, to include dry milk products, shall be Grade A pasteurized. C. Potentially hazardous food such as meat, milk, and custard shall be kept at 45 degrees F or below or at 140 degrees F or above. D. Each refrigerator and freezer shall be provided with an indicating thermometer accurate to plus or minus 3 degrees F, located in	A38	A38 7.8.2.38(c) Director Spoke w/ Cook on Thawing Frozen Meat or Food RE-INFORMED Employee that ALL UNCOOKED MEAT FROZEN OR THAWED MUST BE KEPT AT 45° F. OR LESS. ALL COOKS NEED TO LOOK FAR ENOUGH AHEAD ON MENUS TO PULL FROZEN MEAT SO IT CAN DE-FROST IN REFRIGERATOR. GAVE EMPLOYEE VERBAL WARNING. THIS TIME - IF VIOLATION HAPPENS AGAIN IT WILL BE A FORMAL WRITE-UP. EXPRESSED HOW BACTERIA grow on food - CAUSING RESIDENTS TO BECOME ILL.	9-18-07

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5746	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2007
NAME OF PROVIDER OR SUPPLIER CRANE'S ROOST CARE HOME, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH PARK AVENUE AZTEC, NM 87410		
(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
A38	Continued From Page 7 the warmest section of the refrigeration facility and must be of such type and so situated that the thermometer can be easily read. Thermostats shall not be relied upon to maintain temperatures at correct levels in the absence of thermometers. The temperature of the refrigerator shall be 35 degrees F- 45 degrees F. Freezer temperatures shall be maintained at 0 degrees F or below. E. Refrigerators, freezers, kitchen area and food preparation areas shall be kept clean and sanitary at all times. Food stored in refrigerators/freezers shall be covered, dated, and labeled. Unused leftover food shall be discarded after three days. F. Medication, biological, poisons, detergents, and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications may be stored in the refrigerator with food, if they are labeled and locked in a container marked specifically for medication. G. Dishes, utensils, and preparation equipment shall be properly washed and stored to maintain sanitary conditions. H. All garbage and rubbish shall be stored in containers which are waterproof, easily cleaned and have tight fitting lids. Food waste containers shall be kept in good repair, and shall be kept covered except during use. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 4-7-97; 7.8.2.38 NMAC - Rn, 7 NMAC 8.2.38, 8-31-00] This Requirement is not met as evidenced by: Refer to 7.8.2.38(C) - Potentially hazardous food such as meat shall be kept at 45 degrees F or below or at 140 degrees F or above. Based on observation and interview, the facility failed to properly thaw a turkey at 45 degrees	A38		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5746	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2007
NAME OF PROVIDER OR SUPPLIER CRANE'S ROOST CARE HOME, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH PARK AVENUE AZTEC, NM 87410		
(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
A38	Continued From Page 8 Fahrenheit or below. The findings are: A. On 9/10/07 at 3:30PM during observation of the facility kitchen, it was noted that a frozen turkey was setting out on the kitchen counter in a deep dish at room temperature. B. On 9/10/07 at 3:32PM during interview with the administrator, she stated that the turkey was thawing out on the counter and placed the turkey into the facility refrigerator. Refer to 7.8.2.38(G) - Dishes, utensils, and [food] preparation equipment shall be properly washed and stored to maintain sanitary conditions. Based on observation and interview, the facility failed to ensure that ice machine was properly cleaned. The findings are: A. On 9/11/07 at 10:45AM observation in the facility kitchen, it was noted that what appeared to be black mold spores were attached to the plastic hose immediately above the ice tray in the facility's ice machine. B. On 9/11/07 at 10:46AM observation in the facility kitchen, it was noted that what appeared to be a small fruit fly came out of the facility ice machine when the cover was lifted. C. On 9/11/07 at 10: 47AM during interview with the administrator, she confirmed that the ice machine what appeared to be black mold attached to it and stated that the problem would be addressed.	A38	<i>A 38 7.8.2. (G)</i> <i>Directors Failed to Relize That Mold could grow In Ice Machine WE HAVE A SCHEDULE FOR CLEANING INSIDE FREEZERS, REFRIGERATORS + FILTERS ON THE MOTORS OF ICE MACHINE, But Not Inside Ice Machine or Tubing, Since Inspection on 9-11-07- All Ice was Emptied out + Tubing Cleaned on Evening of 9-11-07, Inside was sprayed + Wiped w/ CLORAX + Tubing was washed w/ CORAX. Directors will schedule This to BE DONE Every 3 months, MAKERS + DEALER OF MACHINE SAID Every 6 months SENT COPIES OF Sanitizer + FILTERS purchased on 9-12-07 ON THE Fruit Fly - WE HAVE Told ALL Employees to KEEP DOORS CLOSED + Wash All Downed Fresh Fruit + Veg - WHEN Brought In to Facility</i>	<i>9-13-07</i>

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5746	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2007
NAME OF PROVIDER OR SUPPLIER CRANE'S ROOST CARE HOME, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH PARK AVENUE AZTEC, NM 87410		
(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
A66	Continued From Page 9	A66		
A66	<p>7 NMAC 8.2.66 RELATED REGULATIONS AND CODES</p> <p>7.8.2.66 RELATED REGULATIONS AND CODES: Adult residential care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows:</p> <p>A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96).</p> <p>B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96).</p> <p>C. Adjudicatory Hearings, New Mexico Department of Health, 7 NMAC 1.2 (2-1-96). [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.66 NMAC - Rn, 7 NMAC 8.2.66, 8-31-00]</p> <p>This Requirement is not met as evidenced by: Refer to NMAC 7.1.9.8 - Caregivers Criminal History Screening Requirements (Effective January 1, 2006) - All applicants to whom an offer of employment is made must consent to a nationwide and statewide screening.</p> <p>Based on record review and interview, the facility failed to have documentation that direct care staff had been cleared through the New Mexico Caregivers' Criminal History Screening Program for 1 re-hired staff member.</p> <p>The findings are:</p> <p>A. On 9/11/07 at 10:12AM during record review, no documentation of an updated clearance letter from the New Mexico Caregivers' Criminal History Screening Program (CCHSP) was seen an employee with a hire date of 6/23/05.</p> <p>B. On 9/11/07 at 10:15AM, during interview with</p>	A66	<p>A66 7 NMAC 8.2.66</p> <p>SINCE INSPECTION ON 9-11-07 DIRECTORS HAVE FINGER PRINTED THE RE-HIRE + NEW EMPLOYEE AND MAILED THEM. DIRECTORS WILL START NEW HIRE POLICY THAT ANY NEW EMPLOYEE SHALL HAVE FINGER PRINTS TAKEN BEFORE TRAINING SCHEDULE WE WILL HOLD FINGER PRINTS TILL THE 20TH DAY OF HIRE IF INDIVIDUAL IS STILL WORKING WE WILL MAIL FINGERPRINTS W/ \$65.00 INTO CRIMINAL HISTORY SCREENING.</p> <p>(1 out of every 6 NEW HIRES MAKE THE CUT and BECOME full time employees - Due to not showing up - JOB PERFORMANCE ect...)</p> <p>ALL FINGER PRINTS MAILED IN BY 9-24-07</p>	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5746	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2007
NAME OF PROVIDER OR SUPPLIER CRANE'S ROOST CARE HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH PARK AVENUE AZTEC, NM 87410		
(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	
A66	Continued From Page 10 . the administrator, she stated that the problem would be corrected. Refer to NMAC 7.1.9.8 - Caregivers Criminal History Screening Requirements (Effective January 1, 2006) - Timely submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than 20 calendar days from the first day of employment or effective date of a contractual relationship with the care provider. Based on record review and interview, the facility failed to have documentation that the application for New Mexico Caregivers' Criminal History Screening (CCHS) clearance had been submitted no later than 20 days from the first day of employment for 1 new employee. The findings are: A. On 9/11/07 at 10:12AM during record review, no documentation verifying submission of application for Caregivers Criminal History Screening for employee hired in July of 2007. B. On 9/11/07 at 10:15AM, during interview with the administrator, she stated that the problem would be corrected.	A66			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.