

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5605 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/29/2008 |
|---|---|---|---|--|
| NAME OF PROVIDER OR SUPPLIER HIGHPOINTE CARE I, LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 6001 ROGERS AVENUE NE ALBUQUERQUE, NM 87110 | | |
| | | <i>ORIGINAL</i> | | |
| (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 01 | OPENING REMARKS Surveyor: 22307 The following deficiencies were cited during a complaint investigation survey conducted on 4/29/08 for New Mexico Regulations Governing Adult Residential Care Facilities 7.8.2 NMAC. Intake # NM 26352 was not Substantiated but Deficiencies were cited. | A 01 | | |
| A22 | 7 NMAC 8.2.22 Resident Records 7.8.2.22 RESIDENT RECORDS: A. RESIDENT RECORDS, CONTENTS: A record for each resident shall be maintained with specific information required. Entries in each resident's record shall be legible, dated, and authenticated by the signature of the person making the entry. Resident records must include: (1) Admission records as set out in Section 7.8.2.21 NMAC: (2) Within five (5) days of admission: (a) An executed admission agreement. (b) A completed resident assessment form. (c) Any available, admission physical examination report by a licensed health care professional, which may include all discharge information from another facility. When admission follows within thirty (30) days discharge from an acute care hospital, the hospital history and physical report, and the hospital discharge summary may serve as an admission physical. (d) Names, addresses, relationship, and phone numbers of family members, and where appropriate, guardians, agents, and any surrogate decision makers. (3) Within thirty (30) days of admission: (a) A admission physical examination report by a licensed health care professional if an examination report was not available within five | A22 | | |

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AUG 20 2008

Division of Health Improvement

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

Yusef Stenmark

TITLE

Director of High Pointe Care LLC

(X6) DATE

8-14-08

STATE FORM

6899

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If continuation sheet 1 of 15

Exhibit 1

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| A22 | Continued From page 1 (5) days of admission. (b) Resident's name, age, recent photograph, social security number, marital status, date of birth, sex, address prior to admission, religion (optional), personal physician, dentist, social history and designated representative or other emergency contact person, language spoken and understood, legal documentation relevant to commitment and/or guardianship status, present medications, and diet required. (c) Any amendments to the admission agreement. (d) The current completed resident assessment form. (e) A completed and current individual service plan. (f) Entries by direct care staff, appropriate health care professionals, or others authorized to care for the resident. Entries shall be dated and signed by the person making the entry and shall include significant information related to the individual service plan. (g) Entries providing a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention, and entries reflecting appropriate follow-up. The maintenance of such written record in the resident record may be by copy of an incident/accident report, if the original incident/accident report is maintained elsewhere by the facility. (h) A medication record: Medications administered by licensed personnel and/or staff assisting with medications to include: listing all currently ordered medications by name, dosage, administration times; documenting by medication | A22 | | |

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| A22 | Continued From page 2 name, dosage, date, and time, each medication administered, with the initials of the individual who administered or assisted with the medication; documentation of errors, omissions, and side-effects of medications; and written consent by resident or guardian for staff to assisting with medications. (i) Date, time and progress note of health services provided by any contract agency. (j) Unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures. (k) Transfer forms completed, signed, and provided to accepting facility when resident is transferring to a hospital or another health care facility. (l) Documentation of disposition of the resident's personal effects and money or valuables deposited with the adult residential care facility, upon death or transfer. B. RESIDENT RECORDS, MAINTENANCE: (1) Resident records shall be maintained and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy for maintaining, and confidentiality of resident records, including the authorized release of resident records. (3) Resident records must be maintained by the facility against loss, destruction, and unauthorized use for a period of not less than three (3) years from the date of discharge. (4) There must be a policy and procedure in place for record retention in the event of facility closure. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 7.8.2.22 NMAC - Rn 7 NMAC | A22 | | |

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| A22 | Continued From page 3 8.2.22, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 22307 Refer to 7.8.2.22 B. (3) Based on observation and interview the facility failed to maintain a resident record at the facility for a period of not less than three (3) years from the date of discharge for 1 of 7 sampled resident's (resident #7). The findings are: A. On 4/29/08 at 1:35 pm, resident #7's record was asked for and caregiver #2 stated the resident resided at another facility and believes the record went with her. During observation of the room that housed the charts, a closed chart was not found for the resident. B. On 4/29/08 at 2:10 pm interview with the administrator stated that they didn't have the chart. She stated the resident had not been at the facility in over a year and they keep the charts in the administrative offices and not at the facility. The chart was not available or provided for review. | A22 | 7 NMAC 8.2.22.B RESIDENT RECORDS 1. The facility administrator was unaware that records had to be kept on the premises for 3 years but now knowing that, she shall have records available, on site for that period of time. 2. Due to a lack of storage space at the facility, the administrator shall find an inside or outside space for the old records. 3. The administrator shall maintain compliance and inform staff of where old charts are to be stored. 4. Date of Completion is 8/31/08 | |
| A27 | 7 NMAC 8.2.27 Individual Services Plan 7.8.2.27 INDIVIDUAL SERVICE PLAN: A. An individual service plan, if prompted by the resident assessment, shall be developed and implemented within fourteen (14) days of admission, and must address those areas of need as identified in the resident assessment. The individual service plan must be reviewed by a licensed nurse at least every six (6) months, and revised as needed at the time of each assessment and consistently implemented in | A27 | | |

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| A27 | <p>Continued From page 4</p> <p>response to the resident's needs.</p> <p>B. The individual service plan must include the following:</p> <ol style="list-style-type: none"> (1) Description of identified needs as noted in the resident assessment. (2) Written description of what services will be provided. (3) Who will provide the services. (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) Goal and outcome of the service. (8) Documentation of the facility's determination that it is able to meet the needs of the resident.. <p>[7-11-86, 1-11-90, 4-7-97; 7.8.2.27 NMAC - Rn, 7 NMAC.8.2.27, 8-31-00]</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 22307</p> <p>Based on observation, record review and interview the facility failed to assess, treat and update the Individual Service Plan (ISP) for two resident's with pressure ulcers (resident #1 and #4) and update one ISP for another resident (resident #2) who had two falls, in which one of the falls resulted in a fracture to her hand. The findings are:</p> <p>A. On 4/29/08 at 12:35 pm interview with resident #1 stated she had a sore on her bottom. On 4/29/08 at 1:55 pm observation of resident #1's right side of her buttocks revealed a stage II pressure ulcer. The facility did not address the pressure ulcer on the ISP dated 1/31/08 or what interventions would be put in place to prevent the pressure ulcer from getting worse. No documentation was found in any part of the medical record that the pressure ulcer had been</p> | A27 | | |

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| A27 | Continued From page 5 identified or what treatment would be done. B. On 4/29/08 at 3:15 pm the administrator stated that all she knew was that resident #1 had to be showered in a certain way. C. On 4/29/08 review of a ledger with caregiver notes was provided and in those notes several entries were made that revealed resident #2 had sustained two falls. The first fall was on 4/14/08 at 3:00 am she was found sitting on the floor, confused. The second fall was on 4/26/08 (no time given) resident #2 was on the floor with a scratch on her forehead and bruised fingers. The resident also had a bruise to her left hand. 1. On 4/26/08 the doctor came out to see the resident and ordered the following x-rays: A. Left foot series for evaluation for fracture status post (S/P) fall. B. Left hand x-ray evaluate for fracture S/P fall with 5th finger bruising and pain. D. On 4/29/08 at 12:30 pm observation of resident #2 revealed a very large bruise to the top of her left hand. Interview with resident #2 stated she did not know how she got the bruise to her left hand. Interview with caregiver #2 stated the resident has a diagnoses of Dementia and had fallen on 4/26/08 and sustained a fracture to her left hand with the bruising. She stated the doctor came to see the resident and ordered x-rays. The x-ray revealed a fracture. Caregiver #2 stated that when they touch her left hand the resident complains of pain. E. On 4/29/08 review of the ISP dated 4/21/08 revealed the resident was not care planned for falls and there was no interventions put in place to prevent the resident from sustaining further falls with injuries. | A27 | 7 NMAC 8.2.27 INDIVIDUAL SERVICE PLANS 1. All residents have an ISP developed within 14 days of admission and at intervals of 6 months. The administrator is now aware that ISP's also need to be changed and updated for any significant change in the resident status and needs. This change in the development and use of ISP's shall be implemented immediately. The administrator is also now aware that even though medical and home health professionals are involved in treating a resident for falls, injuries or pressure ulcers, that the nurse consultant must also be notified to update the ISP's and the staff must be informed for changes in how to perform resident care to meet resident needs. 2. All ISP's and assessments shall be reviewed with the facility staff and the nurse consultant and updated as necessary. 3. The administrator and lead staff person shall call the nurse consultant for any falls, injuries, pressure ulcers, etc. and schedule a time for ISP updates. 4. Date of Completion is 8/30/08. | |

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| A27 | Continued From page 6 F. On 4/29/2008 at 1:47 pm, an observation of resident #4's buttocks (with facility staff) revealed a stage I pressure ulcer. The skin was found to be red and irritated. Review of the resident's medical record at 2:20 pm revealed that the facility did not address the pressure ulcer on the ISP dated 12/19/2007, nor did they document what interventions would be put in place to prevent the pressure ulcer from getting worse on the resident's ISP dated 12/19/2007. There was not any documentation found in the medical record to indicate that the facility had identified the pressure ulcer or were currently treating the wound. | A27 | | |
| A33 | 7 NMAC 8.2.33 Reporting of Incidents 7.8.2.33 REPORTING OF INCIDENTS: A. The facility must insure that all suspected cases or known incidents of resident abuse, neglect, exploitation, and mistreatment are reported. A facility must also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority and Adult Protective Services (APS) by the next business day. In no instance may a facility delay a report to Adult Protective Services or to the Licensing Authority, while an internal investigation is being conducted. B. The facility is responsible for documenting all incidents, within five (5) days of the incident, and having on file, the following: (1) A narrative description of the incident. (2) Results of the facility's investigation. (3) The facility action, if any. [7-1-64, 9-15-70, 5-26-72, 7-11-86, 4-7-97; 7.8.2.33 NMAC - Rn 7 NMAC 8.2.33, 8-31-00] | A33 | | |

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| A33 | Continued From page 7 This REQUIREMENT is not met as evidenced by: Surveyor: 22307 Based on observation, record review and interview the facility neglected to report an incident to the licensing authority by the next business day in which 1 of 7 sampled resident's (resident #2) fell and sustained a fracture to her left hand. The facility also failed to conduct an investigation and what facility action would be put into place to prevent the resident from further harm. The findings are: A. On 04/29/08 review of a ledger with caregiver notes revealed several entries made that resident #2 had sustained two falls. The first fall was on 04/14/08 at 3:00 am she was found sitting on the floor, confused. The second fall was on 04/26/08 (no time given) resident #2 was on the floor with a scratch on her forehead and bruised fingers. The resident also had a bruise to her left hand. 1. On 4/26/08 the doctor came out to see the resident and ordered the following x-rays: A. Left foot series for evaluation for fracture status post (S/P) fall. B. Left hand x-ray evaluate for fracture S/P fall with 5th finger bruising and pain. B. On 04/29/08 at 12:30 pm observation of resident #2 revealed a very large bruise to the top of her left hand. Interview with resident #2 stated she did not know how she got the bruise to her left hand. C. Interview with caregiver #2 stated the resident has a diagnoses of Dementia and had fallen on 04/26/08 and sustained a fracture to her left hand with the bruising. She stated the doctor came to see the resident and ordered x-rays. The x-ray revealed a fracture. Caregiver #2 stated that | A33 | 7NMAC 8.2.33 C. REPORTING OF INCIDENTS 1. The administrator is now aware that any fall resulting in injury or any incident that is suspicious or known to be caused from abuse, neglect or exploitation must be reported to DOH through the use of the incident management system and approved incident report forms. This reporting shall be completed to the DOH within 24 hours of the incident. An internal investigation shall be conducted by the administrator. With the conclusion of the internal investigation, the DOH shall be notified of the findings. 2. All incidents shall be reported as per regulations to the DOH. 3. The administrator or her designee shall assure that all staff are attending the mandatory training to meet state regulations. 4. Date of Completion 8/30/08. | |

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| A33 | Continued From page 8 when they touch her left hand the resident complains of pain. D. On 04/29/08 review of the ISP dated 04/21/08 revealed the resident was not care planned for falls and there was no interventions put in place to prevent the resident from sustaining further falls with injuries. | A33 | | |
| A35 | 7 NMAC 8.2.35 Custodial Drug Permit 7.8.2.35 CUSTODIAL DRUG PERMIT: Any facility licensed pursuant to these regulations who supervises the administration, self-administration, or safeguards medications for residents, must have a current custodial drug permit issued by the State Board of Pharmacy. EXCEPTION: Adult residential care facilities with one (1) resident are not required to have a custodial drug permit. A. PROCUREMENT, LABELING, AND STORAGE: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as required by the individual or specified by the individual's health care plan. The facility shall procure, label, and store medications for residents in a manner which shall be in compliance with state and federal laws. (1) All medications, including non-prescription drugs, will be stored in a locked compartment or in a locked room, as approved by the Board of Pharmacy, and the key will be in the care of the director or designee. (2) Internal medication must be kept separate from external medications. Drugs to be taken by mouth will be separated from all other dosage forms. (3) A separate locked compartment will be available in the refrigerator for those items | A35 | | |

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| A35 | Continued From page 9 labeled "keep in refrigerator." The refrigerator temperature will be kept between thirty-five (35) and forty-five (45) degrees Fahrenheit. A thermometer is required to be kept in the refrigerator. (4) All medications, including non-prescription medications, must be stored in separate compartments for each resident and all medications will be labeled with the residents' names. (5) A resident may be permitted to keep his/her own medication in a secure place in his/her room for self-administration if the physician's report has deemed it appropriate that the resident do so. (6) The facility may not require the resident to purchase prescriptions from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes must comply with National Fire Protection Association (NFPA) 99. B. CONSULTING PHARMACIST: The facility shall maintain records demonstrating the consulting pharmacist provides the following: (1) Reviews the medication regimen as needed, but at least quarterly (every three (3) months), to determine that all medications and records are accurate and current. All irregularities must be reported to the Director of the facility and these irregularities must be acted upon. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation is provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation | A35 | | | |

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| A35 | <p>Continued From page 10</p> <p>in cases involving the use of psychotropic medications. [7-1-64, 9-15-70, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.35 NMAC - Rn, 7 NMAC 8.2.35, 8-31-00]</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22307</p> <p>Refer to 7.8.2.35 A. (1)</p> <p>Based on observation and interview the facility failed to ensure all medications (Meds) are stored in a locked compartment or in a locked room and were not accessible to wandering resident's, visitors or staff. The findings are:</p> <p>A. On 04/29/08 at 12:30 pm, during the initial tour of the facility, the medication (Med) cabinet located in the dining area was found to be unlocked with the key in it and accessible to resident's who wander, visitors and staff. There were numerous residents in the Dining Room at the time eating lunch and in close proximity to the med cabinet. Staff were observed to be in the kitchen and in other parts of the facility and not in direct eye contact with the med cabinet.</p> <p>B. On 4/29/08 at 12:32 am, when caregiver #1 was asked why the cabinet was unlocked, she stated "We were just giving Resident #1 some Tylenol."</p> <p>C. During an interview with resident #1 on 4/29/08 at 12:45 pm, the following medications were noted to be in plain site on the residents nightstand: Calmoseptine ointment, Systane lubricating eye drops (resident stated that they put them in for her), 5 plastic containers of</p> | A35 | <p>7NMAC 8.2.35. CUSTODIAL DRUG PERMIT, LOCKING OF MEDICATIONS</p> <p>1. All staff know that the medication cabinet shall be locked at all times except when taking or putting medications into the cabinet. The medication cabinet is kept locked at all times, effective immediately. All staff know that no medications shall be kept at resident bedsides without a written order from the resident physician stating that the resident may self-administer medications. And then, medications kept at the bedside must be locked and unavailable for other residents. 2. All staff that have access to the medication cabinet have been trained in how to assist with medications and have been reinstructed on the importance of keeping the medication cabinet locked for the safety of all residents and staff and on not keeping medications in resident rooms without self-administer orders from a physician. 3. The administrator or designee shall oversee staff for compliance with this regulation. 4. Date of Completion 8/30/08.</p> | | |

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| A35 | Continued From page 11 Zeasorb antifungal powder, and 2 boxes of Albuterol Sulfate inhaler solution. These medications were not stored under lock and key and would be available to residents and families passing by. The resident's Individual Service Plan (ISP) dated 1/31/08 indicated that the resident #1 was unable to administer her own medications and an order to self administer was not found. Refer to 7.8.2.35 A. (7) Based on observation and interview, the facility failed to ensure that medical gases (oxygen) were stored properly in guidance with the National Fire Protection Association (NFPA) for 1 of 7 sampled residents (resident #2) . The findings are: A. On 4/29/08 at 12:20 pm resident #2 on prescribed oxygen had 3 green cylinder oxygen tanks free standing next to a dresser in residents room, not secured in a rack. B. On 04/29/08 at 12:22 pm, interview with Caregiver #1 stated that 2 tanks were empty and one tank was full. | A35 | 7NMAC 8.2.35 CUSTODIAL DRUG PERMIT, MEDICAL GASES 1. All oxygen tanks at the facility shall be secured in racks or individual carriers. 2. The staff have been trained to call the oxygen suppliers and request racks for any extra oxygen tanks. All unused tanks shall be kept in racks and all tanks in use shall be secured in a carrier. 3. The administrator or designee shall oversee this to be sure that compliance is maintained. 4. Date of Completion 8/30/08. | | |
| A39 | 7 NMAC 8.2.39 Housekeeping/ Laundry Services 7.8.2.39 HOUSEKEEPING/LAUNDRY SERVICES: The adult residential care facility shall maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. The facility must be free from offensive odors, safety hazards, insects and rodents, and accumulations of dirt, rubbish, dust. A. Bathrooms and all common living areas must be cleaned as often as necessary to maintain a clean and sanitary environment. | A39 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5605 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 04/29/2008 |
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| A39 | Continued From page 12 B. Combustibles such as cleaning rags and compounds shall be stored in closed metal containers in approved areas providing adequate ventilation. Combustibles shall be stored away from the food preparation area and away from resident rooms. C. Poisonous or flammable substances must not be stored in residential areas, food preparation areas, or food storage areas. D. The adult residential care facility shall make available laundry services to the residents either on the premises or by use of a commercial laundry or linen service. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (1) All linens shall be changed as needed and at least weekly. (2) The mattress pad, blankets, and bedspread shall be laundered as needed and at least once a month. (3) Bath linens consisting of face towel, bath towel and wash cloth shall be changed as needed and at least three (3) times per week. (4) Residents shall have clean clothing as needed to maintain dignity and be free of odors. E. Laundry services provided on the premises shall have a designated laundry area equipped with a washer and dryer. F. Under no circumstances shall collection, sorting, storage or washing of soiled clothing or linen be done in a food preparation, food storage, or food service area. G. Residents may do their own laundry if they are capable and WISH to do so, or if it is part of a training or rehabilitation program specifically documented in the resident's individual service plan. H. A separate, dry, well ventilated storage area for clean linen shall be provided. | A39 | | | |

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| A39 | Continued From page 13 [7-1-64, 9-15-70, 5-26-72, 7-19-74, 9-24-76, 7-11-86, 4-7-97; 7.8.2.39 NMAC - Rn, 7 NMAC 8.2.39, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 22307 Please refer to 7.8.2.39 B.C. Based on Observation and Interview, the facility failed to ensure that they maintained an environment free of safety hazards and that cleaning Compounds, Poisonous or Flammable substances were not stored and accessible near resident 's rooms and Residential areas. The findings are: A. On 04/29/08 during an initial tour of the facility at 12:20 pm, Cleaning compounds and Poisonous substances were found to be unlocked and accessible to wandering resident's. They were stored in an unlocked Laundry room on the floor underneath and above the sink and in a wire basket next to the sink. The laundry room was located next to the living room where resident's were sitting and watching TV. Items found include: Two (1) gallon bottles of Clorox Bleach with a warning label of Harmful or Fatal if swallowed, one (1) gallon bottle of Windex Window Cleaner and a second 1 (1) gallon bottle 1/4 full, which was also labeled harmful or fatal if swallowed, a can of Pledge Furniture Polish with a warning label of may be Combustible and Harmful or Fatal if swallowed, four Febreze spray bottles, two Shout 28 oz spray bottles, one (1) gallon bottle of Shout, one Elmer's wood glue 7.625 fl oz, one WD 40 13.5 oz oil lubricant spray, four Comet 280 oz bottles, a 1.36 gallon Pine Sol disinfectant cleaner, one gallon of ProForce industrial cleaner, one 19 oz spray battle of Lysol disinfectant and four 24 oz bottles of Odoban (for | A39 | 7NMAC 8.2.39 HOUSEKEEPING/LAUNDRY SERVICES 1. All cleaning products shall be locked and out of accessibility of all residents. 2. To meet the current regulations, all cleaning products are kept locked in the laundry room. Staff have been informed about keeping all cleaning products locked in this room for resident protection and safety. 3. The administrator or designee shall oversee staff and assure that this regulation is always being met. 4. Date of Completion 8/30/08. | |

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| A39 | Continued From page 14 odors). B. On 04/29/08, during the duration of the survey, several residents were observed wandering in and out of rooms and had access to these hazardous substances. C. On 04/29/08 at 3:15 pm, interview with the administrator acknowledged that the hazardous substances should be locked. | A39 | | | |