

PRINTED: 01/16/2007
FORM APPROVED

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/11/2007
NAME OF PROVIDER OR SUPPLIER MILLIE'S CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH HUDSON SILVER CITY, NM 88061		
(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	
A13	7 NMAC 8.2.13 GROUNDS FOR REVOCATION OR SUSPENSION OF LICEN 7.8.2.13 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES: A. When the Licensing Authority determines that an application for renewal of a license is to be denied, or that a license is to be revoked, the Licensing Authority shall provide written notification to the adult residential care facility, the residents of the adult residential care facility and the surrogate decision maker for the resident. B. A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following reasons: 1. Failure to comply with any provision of these regulations. 2. Failure to allow a survey by authorized representatives of the Licensing Authority. 3. Hiring or retaining any employee who has been convicted of a felony or misdemeanor related to abuse, neglect or exploitation, trafficking in controlled substances, criminal sexual penetration or related sexual offenses. 4. Misrepresentation or falsification of any information on application forms or other documents provided to the Licensing Authority. 5. Discovery of repeat violations of these regulations. 6. Failure to provide the required care and services as outlined by these regulations for the residents receiving care from the facility. 7. Exceeding licensed capacity.	A13			

Division of Health Improvement

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

STATE FORM

TITLE

(X6) DATE

9899

NG6511

If continuation sheet 1 of 37

Division of Health Improvement

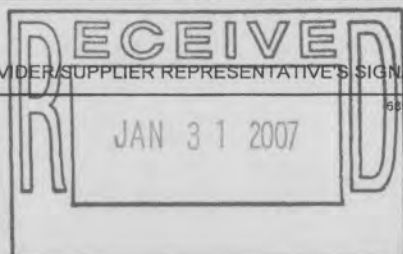
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A13	7 NMAC 8.2.13 GROUNDS FOR REVOCATION OR SUSPENSION OF LICEN 7.8.2.13 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES: A. When the Licensing Authority determines that an application for renewal of a license is to be denied, or that a license is to be revoked, the Licensing Authority shall provide written notification to the adult residential care facility, the residents of the adult residential care facility and the surrogate decision maker for the resident. B. A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following reasons: 1. Failure to comply with any provision of these regulations. 2. Failure to allow a survey by authorized representatives of the Licensing Authority. 3. Hiring or retaining any employee who has been convicted of a felony or misdemeanor related to abuse, neglect or exploitation, trafficking in controlled substances, criminal sexual penetration or related sexual offenses. 4. Misrepresentation or falsification of any information on application forms or other documents provided to the Licensing Authority. 5. Discovery of repeat violations of these regulations. 6. Failure to provide the required care and services as outlined by these regulations for the residents receiving care from the facility. 7. Exceeding licensed capacity.	A13		

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2-6-07*

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A13	Continued From page 1 8. Failure to provide an acceptable plan of correction. 9. Abuse, neglect or exploitation of any patient/client/resident by facility operator, staff or relatives of operator/staff. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 6-15-98; 7.8.2.13 NMAC - Rn, 7 NMAC 8.2.13, 8-31-00] This REQUIREMENT is not met as evidenced by: BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY EXCEEDED LICENSED CAPACITY BY 1 ADULT. RECORD REVIEW ON 1/2/07 REVEALED THE FACILITY IS LICENSED FOR CAPCITY OF 8 ADULTS AND THE FACILITY HAD SIGNED AGREEMENTS TO PROVIDE SERVICES TO 9 ADULTS. DURING AN INTERVIEW WITH THE ADMINISTRATOR ON 1/11/07 AT 8:30 AM, THE ADMINISTRATOR ACKNOWLEDGED THE FACILITY HAD BEEN PROVIDING SERVICES TO 9 ADULTS.	A13			
A19	7 NMAC 8.2.19 ADMISSIONS 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). 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:	A19	7.8.2.13.B.1. Millie's Center had an agreement with Mr. X (lives in his own home but used to drive to Millie's Center) to provide meals and help with medications. We were not aware Mr. X is considered a resident since he doesn't live at Millie's Center. We terminated our contract with Mr. X as of January 25 to insure that Millie's Center does not exceed our licensed capacity of eight residents. Mr. X plans to get help with his medication from Border Area Mental Health. When he eats at Millie's Center he is charged on a per meal basis (as friends or family members are invited to do). Therefore no contractual agreement exists between Mr. X and Millie's Center.		

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A19	Continued From page 2 (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. 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: (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 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	A19	7.8.2.13.B.2. As staff mentioned to the State inspector when he was here, we will soon have the needed repairs done to one of the bathrooms at Millie's Center to apply for a license to have sixteen residents. We strive to apply for an increased license by the end of February 2007. At that point, there will be no problem with the census since we assured entering residents that we will never have more than sixteen residents. 7.8.2.13.B.3. Until our census capacity is increased to sixteen, Millie's Center will not exceed that number.		

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A19	Continued From page 3 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. (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). (c) Be based upon an assessment of the health, safety and well-being of the other facility residents. (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.	A19		

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A19	Continued From page 4 (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] This REQUIREMENT is not met as evidenced by: A. BASED ON INTERVIEW AND RECORD REVIEW THE FACILITY FAILED TO CONVENE A TEAM TO DETERMINE ADMISSION/RETENSION EXCEPTION FOR 2 OF 2 RESIDENTS RECEIVING HOSPICE SERVICES AND FOR 1 RESIDENT RECEIVING NURSING SERVICES FROM A HOME HEALTH AGENCY. 1) DURING AN INTERVIEW WITH THE OFFICE MANAGER ON 1/2/07 AT 4:40 PM, THE OFFICE MANAGER ACKNOWLEDGED RESIDENTS RS-1 AND RS-2 ARE RECEIVING HOSPICE SERVICES AND RESIDENT RS-7 IS RECEIVING NURSING SERVICES FROM A HOME HEALTH AGENCY AND NO TEAM MEETING WAS CONVENED TO DETERMINE IF ADMISSION/RETENSION EXCEPTION WAS AN APPROPRIATE PLACEMENT IN THE FACILITY. 2) RECORD REVIEW ON 1/2/07 AND ON 1/3/07 REVEALED NO DOCUMENTATION OF A TEAM MEETING FOR ADMISSION/RETENSION EXCEPTION FOR RESIDENTS RS-1, RS-2, AND RS-7. B. BASED ON INTERVIEW AND RECORD	A19	7.8.2.19.A.1. We conducted team meetings for Ms. A and Ms. B on January 17 (see enclosed approval sheets). (For the record we only had two residents receiving out-side care when the State investigator was here: Ms. A from Home Health Care, and Ms. B from Hospice.) 7.8.2.19.A.2. Now another resident has started out-patient wound care (Mr. Y) and yet another (Mr. Z) has started Home Health Care physical therapy at Millie's Center. Mollie Wallsteadt, the regional Ombudsman director has been notified of the need for team meetings for these two residents and we expect to meet in the near future. 7.8.2.19.A.3. In the future whenever a resident begins receiving outside care the Ombudsman will be notified immediately by the Office Manager.	DONE

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A19	Continued From page 5 REVIEW THE FACILITY FAILED TO NOTIFY THE LICENSING AUTHORITY OF ADMISSION/RETENSION EXCEPTION FOR 2 OF 2 RESIDENTS RECEIVING HOSPICE SERVICES AND FOR 1 RESIDENT RECEIVING NURSING SERVICES FROM A HOME HEALTH AGENCY. 1) DURING AN INTERVIEW WITH THE OFFICE MANAGER ON 1/2/07 AT 4:40 PM, THE OFFICE MANAGER ACKNOWLEDGED RESIDENTS RS-1 AND RS-2 ARE RECEIVING HOSPICE SERVICES AND RESIDENT RS-7 IS RECEIVING NURSING SERVICES FROM A HOME HEALTH AGENCY WITH NO NOTIFICATION OF LICENSING AUTHORITY OF ADMISSION/RETENSION EXCEPTION. 2) RECORD REVIEW ON 1/2/07 AND ON 1/3/07 REVEALED NO DOCUMENTATION OF NOTIFICATION OF LICENSING AUTHORITY FOR ADMISSION/RETENSION EXCEPTION FOR RESIDENTS RS-1, RS-2, AND RS-7.	A19	7.8.2.19.B.1. Same as 7.8.2.19.A.1. 7.8.2.19.B.2. Same as 7.8.2.19.A.2. 7.8.2.19.B.3. Same as 7.8.2.19.A.3.	DONE
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	A22		

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A22	Continued From page 6 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 (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	A22		

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A22	Continued From page 7 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 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	A22		

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A22	Continued From page 8 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 8.2.22, 8-31-00] This REQUIREMENT is not met as evidenced by: A. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE MEDICATION CONSENT FORMS SIGNED BY RESIDENTS OR GUARDIANS FOR 3 OF 6 RESIDENTS THAT STAFF ARE ASSISTING WITH MEDICATIONS (RS-7, RS-8, RS-10). 1) RECORD REVIEW ON 1/3/06 REVEALED NO SIGNED MEDICATION CONSENT FORMS FOR RESIDENTS RS-7, RS-8, AND RS-10. 2) DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR ON 1/11/07 AT 8:30 AM, THE ADMINISTRATOR ACKNOWLEDGED SHE IS UNABLE TO LOCATE MEDICATION CONSENTS FOR RS-7, RS-8, AND RS-10. B. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE STAFF SIGNATURES ON MEDICATION	A22	7.8.2.22.A.1. Deficiency noted. 7.8.2.22.A.2. As of January 19, all residents have signed Medication Consent Forms. Staff have been instructed and are committed to being more conscious about signatures on consent forms. 7.8.22.C.3. A regular part of staff orientation and meetings will be reminders to sign forms.	DONE	

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A22	Continued From page 9 ASSISTANCE RECORDS (MAR's) FOR 6 OF 6 RESIDENTS THAT STAFF ARE ASSISTING WITH MEDICATIONS (RS-1, RS-2, RS-7, RS-8, RS-10, & RS-21). 1) RECORD REVIEW ON 1/3/06 REVEALED NO STAFF SIGNATURES ON THE MAR's FOR RESIDENTS RS-1, RS-2, RS-7, RS-8, RS-10, & RS-21. 2) DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR ON 1/11/07 AT 8:30 AM, THE ADMINISTRATOR ACKNOWLEDGED THE STAFF HAD NOT BEEN SIGNING THE MAR's. C. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE STAFF SIGNATURES ON CAREGIVER NOTES FOR 10 OF 10 RESIDENTS (RS-1, RS-2, RS-3, RS-4, RS-5, RS-6, RS-7, RS-8, RS-10, & RS-21) (1 DISCHARGED RESIDENT CHART REVIEWED). 1) RECORD REVIEW ON 1/3/07 REVEALED SEVERAL CARE GIVER NOTES WITH NO SIGNATURE OF THE STAFF THAT MADE THE ENTRY ON THE NOTES FOR RESIDENTS RS-1, RS-2, RS-3, RS-4, RS-5, RS-6, RS-7, RS-8, RS-10, & RS-21. 2) DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR ON 1/11/07 AT 8:30 AM, THE ADMINISTRATOR ACKNOWLEDGED THERE WERE CAREGIVER NOTES NOT SIGNED BY STAFF MAKING THE ENTRIES. D. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE	A22	7.8.2.22.B.1. We now have hand-written signature forms on the back of each MARs which has been properly signed. 7.8.2.22.B.2 Current MARs sheets have been signed by everyone certified to assist with medications. 7.8.2.22.B.3. We have developed a computer signature page (see enclosed) that will be copied on the back of each MARs sheet and fillout appropriately. 7.8.2.22.C.1. Immediately following the investigation by the State all staff were instructed that caregiver notes had to be signed. 7.8.22.C.2. We have revised our new employee orientation to make special note of how important it is to read and sign the caregiver notes. We have also reminded staff of this at each of the two staff meetings we've had since the State investigator was here.		

If continuation sheet 11 of 37

Division of Health Improvement

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A22	Continued From page 11 RS-1, RS-6, RS-8, RS-10, AND RS-21 AND ACKNOWLEDGED THAT RESIDENT ASSESSMENTS FOR RS-2 AND RS-4 WERE NOT DONE WITHIN 5 DAYS OF ADMISSION. F. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE INDIVIDUALIZED SERVICE PLANS COMPLETED EVERY 6 MONTHS FOR 4 OF 10 RESIDENTS (RS-2, RS-6, RS-10, AND RS-21) (1 DISCHARGED RESIDENT CHART REVIEWED). 1) RECORD REVIEW ON 1/2/06 REVEALED NO INDIVIDUALIZED SERVICE PLANS COMPLETED IN THE PAST 6 MONTHS FOR RESIDENTS RS-2, RS-6, RS-10, AND RS-21. 2) DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR ON 1/11/07 AT 8:30 AM, THE ADMINISTRATOR FAILED TO PRODUCE INDIVIDUALIZED SERVICE PLANS COMPLETED IN THE PAST 6 MONTHS FOR RESIDENTS RS-2, RS-6, RS-10, AND RS-21. G. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE THE INDIVIDUAL SERVICE PLAN REVIEWED BY A LICENSED NURSE FOR 1 OF 10 RESIDENTS (1 DISCHARGED RESIDENT CHART REVIEWED). 1) RECORD REVIEW ON 1/3/07 REVEALED AN INDIVIDUALIZED SERVICE PLAN WITH NO SIGNATURE(S) OF PERSON(S) WHO DEVELOPED OR REVIEWED THE INDIVIDUALIZED SERVICE PLAN FOR	A22	7.8.22.E.2. Since being advised that repite residents must be treated the same as full- time residents we've not- ified the on-call nurse and she has agreed to be available whenever necessary. 7.8.22.E.3. We've had one admission since the investigation and the on-call nurse came within 72 hours to conduct the assessment. In the future if our regular on-call nurse is unavailable (vacation, etc) we have communicated with an additional nurse to be on call so assessments can be done in a timely manner. 7.8.22.F.1. In the past staffing was downsized because of lack of sufficient income. At this point staffing is complete and there will be no problem with adhering to the six-month requirement for individualized service plans. 7.8.22.F.2. At this point each resident has a current individualized service plan.	DONE	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/11/2007
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A22	Continued From page 12 RESIDENT RS-7. 2) DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR ON 1/11/07 AT 8:30 AM, THE ADMINISTRATOR FAILED TO PRODUCE A SIGNED INDIVIDUALIZED SERVICE PLAN FOR RESIDENT RS-7.	A22	7.8.22.F.3. The office assistant has been assigned the task of reviewing resident files monthly to ascertain that the six-month reviews have been done. A form monitoring this has been developed. (see enclosed).		
A23	7 NMAC 8.2.23 FAC. REPORTS, RECS., P & PS & RULES 7.8.2.23 FACILITY REPORTS/RECORDS/POLICIES AND PROCEDURES/ AND RULES: A. REPORTS AND RECORDS: Each facility must keep the following reports, records, and policy and procedures on file at the facility and make them available for review upon request of the Licensing Authority: (1) Fire Inspection Report. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have fire inspection reports. (2) Copy of the last survey conducted by the Licensing Authority, adverse actions or appeals thereto, and complaints. (3) Copy of the latest survey from Environmental Health Authority (if applicable) regarding kitchen and food management and, if private sewage disposal, and private waste disposal. EXCEPTIONS: Adult residential care facilities with three (3) or fewer residents are not required to be inspected by Environmental Health Authority. Facilities exempted by the Environmental Health Authority having jurisdiction, are not required to have a survey on file provided the exemption letter is on file. (4) TB test results of staff or any of their family members living in the facility. (5) One (1) month of menus planned	A23	7.8.2.22.G.1. The office assistant reviewed the files and found the list of discrepancies. 7.8.2.22.G.2. All the individualized service plans been reviewed and each has been signed by a licensed nurse. 7.8.22.G.3. The office assistant has been assign the responsibility of reviewing every individual service plan to make sure it has the appropriate signature. In addition each new plan is summarized at our next staff meeting.	DONE	

Division of Health Improvement

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A23	Continued From page 13 and as served. (6) Record of fire drills: A record of all fire drills conducted at the facility. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to hold or record fire drills. (7) Written emergency plans and policies and procedures for medical emergencies, power failure, fire or natural disaster. Such plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes and refuge areas, responsibilities of personnel. (8) Licensing regulations: A copy of these regulations (Requirements for Adult Residential Care Facilities, 7.8.2 NMAC). (9) Custodial Drug Permit: A valid Custodial Drug Permit issued by the State Board of Pharmacy for those facilities licensed pursuant to these regulations. EXCEPTION: Adult residential care facilities with only one (1) resident are not required to have a custodial drug permit. (10) Vaccination of pets in the facility. (11) Staff training. (a) At orientation and on-going. (b) Appropriate to staff responsibilities. (Assistance with medications, dietary, environmental...) (c) Fire safety. (d) First aid. (e) Safe food handling practices. (f) Confidentiality of records and resident information. (g) Infection control (including universal precautions and linen handling). (h) Resident rights. (i) Providing Quality Resident care based on current resident need. (j) Reporting requirements for Abuse, Neglect or Exploitation.	A23		

Division of Health Improvement

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A23	Continued From page 14 (12) A copy of License. (13) Employee personnel records, including an application for employment, TB certificates, training records, and personnel actions. (14) A copy of all WAIVERS/VARIANCES granted by the Licensing Authority. (15) A copy of the floor plans as approved for licensure. B. RULES: Prior to placement in or admission to a facility, a prospective resident or his/her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to but not limited to the following: (1) The use of tobacco and alcohol. (2) The use of the telephone. (3) Operation of television, radio, and stereo. (5) Use and safekeeping of personal property. (6) Meals. (7) Use of common areas. (8) Electric blankets or appliances used by residents. C. POLICIES AND PROCEDURES: All facilities shall have written policies and procedures covering the following areas: (1) Actions to be taken in case of accidents or emergencies, (e.g., gas leaks, injuries, transportation, medications,...). (2) Method of keeping informed when residents go outside of the facility (e.g., sign-out sheets). (3) The handling of resident's funds, if the facility provides such services. (4) Reporting of incidents, including abuse, neglect, and exploitation. (5) Handling of complaints. (6) Staff and resident fire and safety training.	A23			

Division of Health Improvement

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A23	Continued From page 15 (7) Smoking. (8) The facility's bed hold policy. (9) Admission agreement. (10) Admission records. (11) Resident records. (12) Program Narrative. (13) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (14) Personnel policies. (15) Identifying and safeguarding resident possessions. (16) Securing medical assistance if a resident's own physician is not available. (17) NOTE FOR MATERNITY SHELTERS ONLY: In addition to the required policy and procedure topics listed above, Maternity Shelters shall have written policies and procedures regarding infant formula, feeding and equipment, and laundering of infant linen and diapers. (18) Staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles. (19) Staff training for employees who operate motor vehicles to transport residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.23 NMAC - Rn & A 7 NMAC 8.2.23, 8-31-00] This REQUIREMENT is not met as evidenced by: BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE DOCUMENTATION OF STAFF TRAINING FOR 2 OF 3 STAFF (S-12, AND S-13). RECORD REVIEW ON 1/2/07 REVEALED NO DOCUMENTATION OF ORIENTATION OR REQUIRED TRAININGS FOR STAFF S-13 AND	A23	7.8.2.23.C.1. Although staff training occurred, the proper documentation was not done. 7.8.2.23.C.2. We have revamped our staff orientation (see enclosed) to include all the missing pieces that the State investigator pointed out to us. 7.8.2.23.C. . We have developed a Staff Training Sheet that is stored in each employee's file that lists the training topic and the date, beginning January 1, 2007.	DONE	

Division of Health Improvement

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A23	Continued From page 16 FIRE DRILL TRAINING ONLY FOR STAFF S-12. DURING AN INTERVIEW WITH THE OFFICE ADMINISTRATOR ON 1/2/07 AT 3:30 PM, THE OFFICE ADMINISTRATOR ACKNOWLEDGED THERE WAS NO DOCUMENTATION FOR ORIENTATION AND TRAININGS FOR S-12 AND S-13.	A23		
A26	7 NMAC 8.2.26 RESIDENT ASSESSMENT 7.8.2.26 RESIDENT ASSESSMENT: A. A resident assessment to determine level of function and if the client's needs can be met by the facility. The initial assessment must be completed within five (5) days of admission and reviewed every six (6) months as part of the individual service plan. B. The resident assessment must establish a baseline in the resident's functional status and thereafter, identify resident changes through periodic reassessments. C. The resident assessment must be documented on a state approved resident assessment form and at a minimum include the following: (1) Cognitive patterns. (2) Communication/hearing patterns. (3) Vision patterns. (4) Physical functioning and structural problems. (5) Continence. (6) Psycho social well-being. (7) Mood and behavior patterns. (8) Activity pursuit patterns. (9) Disease diagnoses. (10) Health conditions. (11) Oral/nutritional status. (12) Oral/dental status. (13) Skin conditions.	A26		

Division of Health Improvement

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A26	Continued From page 17 (14) Medication use. (15) Special treatment and procedures. D. The resident admission assessment, the physical exam report, and the observation and evaluation of staff with regards to the needs will be used to develop the individual service plan, if needed. If the resident assessment does not indicate a need for an individual service plan, then an individual service plan is not required. However, an individual service plan must be prepared for residents requiring nursing services. [4-7-97; 7.8.2.26 NMAC - Rn, 7 NMAC 8.2.26, 8-31-00] This REQUIREMENT is not met as evidenced by: A. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE A RESIDENT ASSESSMENT COMPLETED WITHIN 5 DAYS OF ADMISSION TO THE FACILITY FOR 7 OF 10 RESIDENTS (RS-1, RS-6, RS-8, RS-10, RS-21, RS-2, AND RS-4) (1 DISCHARGED RESIDENT CHART REVIEWED). 1) RECORD REVIEW ON 1/3/07 REVEALED RESIDENT ASSESSMENTS WERE NOT ON FILE FOR RESIDENTS RS-1, RS-6, RS-8, RS-10, AND RS-21 AND RESIDENT ASSESSMENTS WERE DATED AFTER THE 5 DAY FROM ADMISSION DATE FOR RESIDENTS RS-2, AND RS-4. 2) DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR ON 1/11/07 AT 8:30 AM, THE ADMINISTRATOR FAILED TO PRODUCE RESIDENT ASSESSMENTS FOR RESIDENTS RS-1, RS-6, RS-8, RS-10, AND RS-21 AND ACKNOWLEDGED THAT RESIDENT ASSESSMENTS FOR RS-2 AND RS-4 WERE NOT DONE WITHIN 5 DAYS OF ADMISSION.	A26	7.8.2.26.A.1. DONE Although some of the assessments were not done in a timely manner, all residents now have one in their file. 7.8.2.26.A.2. Since being advised that respite residents must be treated the same as full-time residents we've notified the on-call nurse and she has agreed to be available whenever necessary. 7.8.2.26.A.3. We've had one admission since the investigation and the on-call nurse came within 24 hours to conduct the assessment. In the future if our regular on-call nurse is unavailable (vacation, etc) we have communicated with an additional nurse to be on call so assessments can be done in a timely manner.	

Division of Health Improvement

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A27	Continued From page 18	A27		
A27	7 NMAC 8.2.27 INDIVIDUAL SERVICE 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 response to the resident's needs. B. The individual service plan must include the following: (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. [7-11-86, 1-11-90, 4-7-97; 7.8.2.27 NMAC - Rn, 7 NMAC.8.2.27, 8-31-00] This REQUIREMENT is not met as evidenced by: A. BASED ON INTERVIEW AND RECORD REVIEW THE FACILITY FAILED TO DOCUMENT HOSPICE SERVICES AND HOME HEALTH SERVICES ON THE INDIVIDUALIZED SERVICE PLAN FOR 2 OF 2 RESIDENTS RECEIVING HOSPICE SERVICES AND FOR 1 RESIDENT RECEIVING NURSING SERVICES FROM A HOME HEALTH AGENCY (RS-1, RS-2,	A27	7.8.2.27.A.1. Communication between Millie's Center employees and Hospice had been informal but frequent and friendly. 7.8.2.27.A.2. A new individualized service plan was created for both the Hospice resident and the resident receiving Home Health nursing as a result of the team meeting held on January 17. At this point both the outside agencies have Millie's Center individualized service plans and Millie's Center has each of their individualized service plans. 7.8.2.27.A.3. A sign-in sheet for the one person on Hospice is now included in the MARs folder. The Hospice nurse signs in each time he visits and makes notes on that sheet. Millie's Center employees also write notes on that sheet to the Hospice nurse.	DONE

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/11/2007
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A27	Continued From page 19 AND RS-7) . 1) DURING AN INTERVIEW WITH THE OFFICE MANAGER ON 1/2/07 AT 4:40 PM, THE OFFICE MANAGER ACKNOWLEDGED RESIDENTS RS-1 AND RS-2 ARE RECEIVING HOSPICE SERVICES, RESIDENT RS-7 IS RECEIVING NURSING SERVICES FROM A HOME HEALTH AGENCY AND THE SERVICES ARE NOT DOCUMENTED ON THE INDIVIDUALIZED SERVICE PLAN. 2) RECORD REVIEW ON 1/2/07 AND ON 1/3/07 REVEALED NO DOCUMENTATION OF HOSPICE SERVICES OR HOME HEALTH SERVICES ON THE INDIVIDUALIZED SERVICE PLAN FOR RESIDENTS RS-1, RS-2, AND RS-7. B. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE INDIVIDUALIZED SERVICE PLANS COMPLETED EVERY 6 MONTHS FOR 4 OF 10 RESIDENTS (RS-2, RS-6, RS-10, AND RS-21). (1 DISCHARGED RESIDENT CHART REVIEWED). 1) RECORD REVIEW ON 1/2/06 REVEALED NO INDIVIDUALIZED SERVICE PLANS COMPLETED IN THE PAST 6 MONTHS FOR RESIDENTS RS-2, RS-6, RS-10, AND RS-21. 2) DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR ON 1/11/07 AT 8:30 AM, THE ADMINISTRATOR FAILED TO PRODUCE INDIVIDUALIZED SERVICE PLANS COMPLETED IN THE PAST 6 MONTHS FOR RESIDENTS RS-2, RS-6, RS-10, AND RS-21.	A27	7.8.2.27.B.1. In the past staffing was downsized because of lack of sufficient income. At this point staffing is complete and there will be no problem with adhering to the six-month review requirement for individualized service plans. 7.8.2.27.B.2. At this point each resident has a current individualized service plan. 7.8.2.27.B.3. The office assistant has been assigned the task of reviewing the resident files monthly to ascertain that the six-month reviews have been done. A form monitoring this has been developed (see enclosed).	DONE

Division of Health Improvement

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A27	Continued From page 20 C. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE THE INDIVIDUAL SERVICE PLAN REVIEWED BY A LICENSED NURSE FOR 1 OF 10 RESIDENTS (RS-7) (1 DISCHARGED RESIDENT CHART REVIEWED). 1) RECORD REVIEW ON 1/3/07 REVEALED AN INDIVIDUALIZED SERVICE PLAN WITH NO SIGNATURE(S) OF PERSON(S) WHO DEVELOPED OR REVIEWED THE INDIVIDUALIZED SERVICE PLAN FOR RESIDENT RS-7. 2) DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR ON 1/11/07 AT 8:30 AM, THE ADMINISTRATOR FAILED TO PRODUCE A SIGNED INDIVIDUALIZED SERVICE PLAN FOR RESIDENT RS-7.	A27	7.8.2.27.C.1. The office assistant re- viewed the files and found the list of discrepancies. 7.8.2.27.C.2. All the individualized service plans for current residents have been reviewed and each has been signed by a licensed nurse. 7.8.2.27.C.3. The office assistant has been assigned the responsibility of reviewing every individual service plan to make sure it has the appropriate signature.	DONE
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	A35		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/11/2007
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A35	Continued From page 21 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 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)	A35			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/11/2007
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A35	Continued From page 22 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 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] This REQUIREMENT is not met as evidenced by: BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE THE CONSULTING PHARMACIST REVIEW THE MEDICATION REGIMEN FOR THE MINIMUM OF AT LEAST EVERY 3 MONTHS FOR 6 OF 6 RESIDENTS THAT THE FACILITY IS PROVIDING ASSISTANCE WITH MEDICATIONS. RECORD REVIEW ON 1/11/07 REVEALED THE CONSULTING PHARMACIST REVIEWED THE MEDICATION REGIMENT ON 6/12/06 AND DID NOT REVIEW AGAIN UNTIL 12/12/06. DURING THE EXIT INTERVIEW WITH THE ADMINISTRATOR ON 1/11/07 AT 9:20 AM, THE ADMINISTATOR ACKNOWLEDGED THE CONSULTING PHARMACIST HAD NOT BEEN REVIEWING THE MEDICATION REGIMEN EVERY 3 MONTHS.	A35	7.8.2.35.B.1. Our consulting pharmacist had been coming every six months. 7.8.2.B.2. We had a conversation with our consulting pharmacist, and asked that he come every three months. 7.8.2.35.B.3. Our consulting pharmacist notified us in a letter dated January 25 (enclosed) that he will now be conducting a review every three months. In 2007 he will conduct a review in March, June, September, and December.	DONE	

Division of Health Improvement

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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 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	A38		

Division of Health Improvement
STATE FORM

If continuation sheet 26 of 37

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/11/2007
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A44	7 NMAC 8.2.44 HAZARDOUS AREAS 7.8.2.44 HAZARDOUS AREAS: A. Hazardous areas, as defined per NFPA 101 (Life Safety Code), on the same floor as, and in or abutting a primary means of escape or a sleeping room shall be protected by either; (1) Enclosure of at least one hour fire rating with self closing or smoke operated automatic closing fire doors having a 3/4 hour rating or; (2) Automatic fire protection (sprinkler) and separation of hazardous area with any doors self-closing or automatic-closing on smoke detection. (3) Other hazardous areas shall be enclosed with walls having at least a twenty (20) minute fire rating and doors equivalent to 1 3/4 inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. All boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one-hour. Doors to these rooms shall be 1-3/4" solid core. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have a fire resistance rating of not less than one-hour or the 1-3/4" solid core door. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.44 NMAC - Rn, 7 NMAC 8.2.44, 8-31-00] This REQUIREMENT is not met as evidenced by: BASED ON OBSERVATION AND INTERVIEW THE FACILITY FAILED TO HAVE A SELF CLOSING OR SMOKE OPERATED AUTOMATIC CLOSING DOOR TO THE LAUNDRY ROOM WHERE CHEMICALS ARE STORED.	A44	7.8.2.38.D.3. continued have been instructed that the lids must be secured except during meal preparation and clean-up. 7.8.2.44.B.1. Deficiency noted. 7.8.2.44.B.2. An automatic closing spring has been installed on the laundry room door. 7.8.2.44.B.3. The automatic closing spring will be in place and maintained from now on.	DONE

Division of Health Improvement

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A44	Continued From page 27 TOUR OF THE FACILITY ON 1/2/07 REVEALED THE DOOR TO THE LAUNDRY ROOM/CHEMICAL STORAGE ROOM DID NOT HAVE ANY SELF CLOSING OR SMOKE OPERATED AUTOMATIC CLOSING DEVICE. DURING AN INTERVIEW WITH THE OFFICE MANAGER ON 1/2/07, THE OFFICE MANAGER ACKNOWLEDGED THERE IS NO SELF CLOSING OR SMOKE OPERATED AUTOMATIC CLOSING DEVICE ON THE DOOR TO THE LAUNDRY ROOM/CHEMICAL STORAGE ROOM.	A44		
A45	7 NMAC 8.2.45 HEATING, VENTILATION AND AIR-CONDITIONING 7.8.2.45 HEATING, VENTILATION AND AIR-CONDITIONING: A. Heating, air-conditioning, piping, boilers, and ventilation equipment must be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities must have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. B. The heating method used by the facility must provide a minimum temperature of seventy (70) degrees Fahrenheit in all rooms used by the residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device may be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances must be permanently anchored and kept away from flammables such as curtains, bedcoverings, trash containers, or clothing. No heating appliance	A45		

Division of Health Improvement

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A45	Continued From page 28 shall be located where the unit or wiring is a tripping hazard or danger from electrical shock. D. Fireplaces and open flame heating are not permitted to be utilized in sleeping rooms. E. Gas fired water heaters must not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms. F. A facility must be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means. G. All openings to the outside air used for ventilation must be screened for the control of insects and rodents. Screen doors must be equipped with self-closing devices. H. A facility must be provided with a system for maintaining residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard or danger from electrical shock. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7-1-64, 9-15-70 9-24-76, 7-11-86, 4-7-97; 7.8.2.45 NMAC - Rn, 7 NMAC 8.2.45, 8-31-00] This REQUIREMENT is not met as evidenced by: BASED ON OBSERVAION AND INTERVIEW THE FACILITY FAILED TO PROPERLY SCREEN WINDOWS USED FOR VENTILATION ON 1 RESIDENT ROOM, 1 RESIDENT BATHROOM, 2 KITHCEN WINDOWS, ONE CORRIDOR WINDOW, AND 1 IN THE LAUNDRY ROOM. TOUR OF THE EXTERIOR OF THE FACILITY ON 1/2/07 REVEALED TORN SCREENS ON RESIDENT ROOM 11's WINDOW, RESIDENT BATHROOM R7's WINDOW, 2 KITCHEN	A45	7.8.2.45.H.1. DONE We had the screens replaced within the last 18 months and did not realize that cat claws caused holes big enough to be a deficiency. The small tear (approx 1 inch) in room 11 had not been observed. Also the screens that had become dislodged from the frames in the kitchen had not been noted. 7.8.2.45.H.2. We have already repaired or purchased new screens. They have been installed in resident room 11, bathroom R7, two kitchen windows, and one laundry room window. We also found the screen that was missing and installed it in the east corridor.	

Division of Health Improvement

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A45	Continued From page 29 WINDOWS, AND 1 LAUNDRY ROOM WINDOW. THE EAST WINDOW TO THE EAST EXIT CORRIDOR HAD NO SCREEN. DURING AN INTERVIEW WITH THE OFFICE MANAGER ON 1/2/07 AT 11:10 AM, THE OFFICE MANAGER ACKNOWLEDGED THE SCREENS ARE TORN OR MISSING.	A45		
A46	7 NMAC 8.2.46 WATER 7.8.2.46 WATER: A. A facility must be provided with an adequate supply of water which is of a safe and sanitary quality suitable for domestic use. Hot and cold running water under pressure must be distributed to all food preparation areas, lavatories, washrooms, and laundries. B. If the water supply is not obtained from an approved public system, the private water system must be inspected, tested, and approved by the Environmental Health Authority prior to licensure. It is the facility's responsibility to insure that subsequent periodic testing or inspection of such private water systems be made at intervals as prescribed by the Environmental Authority. C. The hot water temperature accessible to residents must be maintained at a minimum of 95 degrees Fahrenheit and a maximum of 110 degrees Fahrenheit. Hot water in excess of 110 degrees Fahrenheit is permitted in kitchen and laundry areas, provided residents are supervised to prevent injury. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.46 NMAC - Rn, 7 NMAC 8.2.46, 8-31-00] This REQUIREMENT is not met as evidenced by: BASED ON OBSERVATION AND INTERVIEW THE FACILITY FAILED TO MAINTAIN HOT	A46	7.8.46.C.1. Since the State inspector brought it to our attention that the water temperature in several resident restrooms was too hot we have monitored it more closely. 7.8.46.C.2. One water heater in particular needed more attention, but we are confident that the temperature is consistently	DONE

Division of Health Improvement

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A46	Continued From page 30 WATER TEMPERATURE BELOW 110 DEGREES FAHRENHIET IN 3 OF 4 RESIDENTS BATHROOMS (B-2, B-3, B-4, & R-2). TOUR OF THE FACILITY ON 1/2/07 REVEALED HOT WATER TEMPERATURES IN RESIDENTS' BATHROOMS OF 122 DEGREES FAHRENHIET IN R-2, 112 DEGREES FAHRENHIET IN B-2, AND 119 DEGREES FAHRENHIET IN B-4. DURING AN INTERVIEW WITH THE OFFICE MANAGER AT 2:00 PM, THE OFFICE MANAGER WAS UNAWARE OF THE MAXIMUM HOT WATER TEMPERATURE LIMIT IN THE REGULATIONS.	A46	7,8,46,C,2, continued at a temperature of below 110 degrees. 7.8.2.46.C.3. The office assistant will test the water at minimum on a monthly basis, and be sure to include all of the resident bathrooms (see enclosed).		
A49	7 NMAC 8.2.49 ELEMENTS OF FACILITY ELECTRICAL SYSTEM 7.8.2.49 ELEMENTS OF FACILITY ELECTRICAL SYSTEM: A. All fuse and breaker boxes must be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility must know the location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances must be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear. (2) Extension cords are prohibited. EXCEPTION: The use of a multi-socket United Laboratories approved (U/L APPROVED) surge protector with integrated circuit breaker no greater than six (6) foot in length is permitted.	A49			

Division of Health Improvement

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A49	Continued From page 31 [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.49 NMAC - Rn, 7 NMAC 8.2.48, 8-31-00] K This REQUIREMENT is not met as evidenced by: A. BASED ON OBSERVATION AND INTERVIEW THE FACILITY FAILED TO PROHIBIT THE USE OF EXTENSION CORDS. 1) TOUR OF THE FACILITY ON 1/2/07 REVEALED THE FOLLOWING 3 EXTENSION CORDS IN USE: EXTENSION CORD IN LIVING AREA TO POWER A TABLE LAMP, EXTENSION CORD TO POWER CHRISTMAS TREE LIGHTS, AND EXTENSION CORD TO POWER COFFEE MAKERS IN DINING AREA. 2) IN AN INTERVIEW WITH THE OFFICE MANAGER ON 1/2/07 AT 4:00 PM, THE OFFICE MANAGER ACKNOWLEDGED SHE DID NOT KNOW EXTENSION CORDS WERE PROHIBITED. B. BASED ON OBSERVATION THE FACILITY FAILED TO HAVE CIRCUIT BREAKERS LABELED TO INDICATE THE AREA OF THE FACILITY TO WHICH EACH CIRCUIT BREAKER PROVIDES SERVICE. 1) TOUR OF THE FACILITY ON 1/2/07 REVEALED THAT ONLY HALF OF THE CIRCUIT BREAKERS WERE LABELED WITH MANY OF THE LABELS NOT LEGIBLE. 2) IN AN INTERVIEW WITH THE	A49	7.8.2.49.A.1. Deficiency noted. Millie's Center staff had been informed by the fire marshal that commercial grade extension cords were permissible. 7.8.2.29.A.2. Extension cords in the living room to the Christmas tree and a lamp have been removed. The extension cord to the coffee makers in the dining room has been replaced by a U/L approved surge protector less than six feet long. 7.8.2.49.A.3. In addition we have obtained estimates from two electricians (see enclosed) to rewire resident rooms, and we plan to accept one of the estimates in the near future so work can begin. 7.8.2.49.B.1. Deficiency noted.	2-2-07	2-2-07

Division of Health Improvement

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A49	Continued From page 32 ADMINISTRATOR ON 1/11/07 AT 8:30 AM, THE ADMINISTRATOR ACKNOWLEDGED THE CIRCUIT BREAKERS WERE NOT LABELED PROPERLY.	A49	7.8.2.49.B.2. We have an agreement with a contractor to test and label the circuit breakers next week. We will monitor the handwriting on the labeling to make sure it is clearly legible to all.	
A63	7 NMAC 8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING 7.8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff personnel of the facility must know the location of and be instructed in proper use of fire extinguishers and other procedures to be observed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff must be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways, and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident must upon being accepted into the facility be given an orientation tour of the facility to include, but not be limited to, the location of the exits, fire extinguishers, and telephones, and shall be instructed in action to be taken in case of fire or other emergency. D. Fire Drills: The facility must conduct at least one (1) fire drill each month: (1) Fire drills must be held at different times of the day. (2) The fire alarm system or detector system in the facility shall be used in the conduct of fire drills. (3) In the conduct of fire drills, emphasis must be placed upon orderly evacuation under	A63	7.8.2.49.B.3. In the future the labeling will be clear and legible. This will be reviewed each January when the survey findings are reviewed.	

Division of Health Improvement

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A63	Continued From page 33 proper discipline rather than upon speed. (4) A record of fire drills held must be maintained on file in the facility. Such record must show date and time of the drill, number of personnel participating in the drill, any problem noted during the drill and the evacuation time in total minutes. (5) The local fire department should be requested to supervise and participate in fire drills. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.63 NMAC - Rn, 7 NMAC 8.2.63, 8-31-00] This REQUIREMENT is not met as evidenced by: A. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE A RECORD OF MONTHLY FIRE DRILLS. 1) RECORD REVIEW ON 1/2/07 REVEALED NO DOCUMENTATION OF FIRE DRILLS FOR JAN, APR, MAY, JUNE AUG, OCT, OR DEC. OF 2006. 2) IN AN INTERVIEW WITH THE OFFICE MANAGER ON 1/2/07 AT 2:48 PM, THE OFFICE MANAGER ACKNOWLEDGED THERE IS NO RECORD OF FIRE DRILLS FOR THE MONTHS LISTED ABOVE. B. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO USE THE FIRE ALARM TO CONDUCT FIRE DRILLS. 1) RECORD REVIEW ON 1/2/07 REVEALED NO DOCUMENTATION OF THE FIRE ALARM SYSTEM BEING USED TO CONDUCT FIRE DRILLS.	A63	7.8.2.63.A.1. Deficiency noted. 7.8.2.63.A.2. The office manager has been assigned the duty of documenting our monthly fire drills in our ledger so that the information will be available for inspections. 7.8.2.63.A.3. Since the State inspection we have begun regular fire drills, an have made sure they are documented in the appropriate file. We will conduct fire drills at least once a month. The fire marshal has agreed to participate in our next fire drill. 7.8.2.63.B.1. Deficiency noted. 7.8.2.63.B.2. We have learned how to use the fire alarm in our fire drills and will use it in	2-9-07 2-9-07	

Division of Health Improvement

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A63	Continued From page 34 2) DURING AN INTERVIEW WITH THE OFFICE MANAGER ON 1/2/07 AT 2:07 PM, THE OFFICE MANAGER ACKNOWLEDGED THE FIRE ALARM IS NOT USED TO CONDUCT FIRE DRILLS.	A63	7.8.2.63.B.2. continued the next fire drill we conduct (next week). 7.8.2.63.B.3. In the future the fire alarm will be used in each fire drill.	
A66	7 NMAC 8.2.66 RELATED REGULATIONS AND CODES 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: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96). B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96). 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] This REQUIREMENT is not met as evidenced by: A. BASED ON RECORD REVIEW AND INTERVIEW THE FACILITY FAILED TO HAVE ON FILE CRIMINAL HISTORY SCREENING (CCHS) CLEARANCE LETTER FOR 1 OF 3 STAFF (S-12) (NMAC 7.1.9 CCHS). 1) RECORD REVIEW ON 1/2/07 REVEALED NO CCHS CLEARANCE LETTER FOR STAFF S-12 WITH A HIRE DATE OF 11/25/06. 2) DURING AN INTERVIEW WITH THE OFFICE MANAGER ON 1/2/07 AT 3:45 PM, THE OFFICE MANAGER STATED STAFF S-12 HAS	A66	7.8.2.66.A.1. The staff person mentioned in the survey recently quit due to carpal tunnel. She worked weekends only and been asked repeatedly to submit finger prints and had not done so. 7.8.2.66.A.2. The employee should have been informed that she wouldn't receive a paycheck after 15 days of hire if she did not provide finger prints. 7.8.2.66.A.3. In the future, if an employee does not provide finger prints within 15 days of hire, his/her employment will be suspended until s/he does so.	2-15-07

Division of Health Improvement
STATE FORM

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/11/2007
NAME OF PROVIDER OR SUPPLIER MILLIE'S CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH HUDSON SILVER CITY, NM 88061		
(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 36 ADMINISTRATOR ACKNOWLEDGED THE INQUIRY TO THE EMPLOYEE ABUSE REGISTRY WAS MADE ON 11/13/06 FOR STAFF S-13 AFTER THE HIRE DATE OF 10/18/06 AND NO INQUIRY WAS MADE TO EMPLOYEE ABUSE REGISTRY FOR STAFF S-12.	A66	7.8.2.66.C.2. continued be simple in the future to contact the EAR before hiring. 7.8.2.66.C.3. In the future the office manager will always attempt to get information from EAR before hiring.		