Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2039	A. BUILDING: _____ B. WING _____	C 08/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA SPRINGS ASSISTED LIVING	503 LOS LENTES ROAD NE LOS LUNAS, NM 87031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a full on-site survey completed on 08/11/15 for the New Mexico Requirements for Assisted Living for Adults, 7.8.2 NMAC. Complaints NM #29703 and NM #29742 were substantiated.	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC. B. Direct care staff: (1) shall be at least eighteen (18) years of age;	A 016	Scanned 11-03-15 J.D. The violation regarding the fact that the administrator had not completed a state approved certification program for Assisted Living administrators was corrected by: The administrator completed a state approved administrator's program on 8/11/15. The certificate of completion is now filed in the administrator's file. This corrective action will be monitored by adding this state requirement to our administrator requirements for employment listed in our policies and procedures manual, and also to our administrator orientation sheet. 10/10/15	

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Frances Johnson — TITLE: Administrator — (X6) DATE: 10/14/15

STATE FORM 6899 NVR411 If continuation sheet 1 of 74

HEALTH FACILITY LICENSURE & CERTIFICATION BUREAU
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A 016	Continued From page 1 (2) shall have adequate education, relevant training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010]	A 016	The violation of not submitting a EAR request for clearance prior to hiring will be corrected by: The hiring supervisor will submit a request for clearance by the EAR program. Documentation of each inquiry will be kept in each employees file. We - the hiring supervisor will also submit the CCHS screening within 20 days of hire for all employees. We will monitor this corrective action by: Our application for employment will include the question Did you inquire of the EAR for this	

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A 016	Continued From page 2 This REQUIREMENT is not met as evidenced by: 7.8.2.16 A(4), B (3) (6) Based of record review and interview the facility failed to ensure that: 1. the Administrator (Admin) had completed a state approved certification program for Assisted Living Administrators. 2. the facility complied with the pre-employment requirements pursuant to the Employee Abuse Registry (EAR) 7.1.12 NMAC. 3. the facility complied with the requirements of the Caregivers Criminal History Screening (CCHSP) 7.1.9 NMAC within 20 days of employment. If the Admin has not completed and received certification from an Assisted Living Administrators course and direct care staff have not received EAR/CCHSP clearances in the required time frames, then all 15 (R #1-15) residents, identified on the resident census, provided by the Admin on 08/04/15 are at risk of being provided care by an administrator who is not qualified and direct care staff who had a previous history of abusing, neglecting, or exploiting individuals under their care or be convicted felons. The findings are. Findings related to the Administrator's certification. A. Record review of requested documents revealed no Certificate of Completion from a state approved program for assisted living administrators for the Admin. B. On 08/07/15 at 1:50 pm, during interview with the Admin she confirmed that she did not have a Certificate of Completion of a state	A 016	applicant? yes or no. Also the statement: Caregivers are required to receive clearance from the EAR prior to hiring. will be added to the application for employment. Inorder to ensure ongoing compliance regarding the CCHSP, the application for employment will also include the statement: I am aware of the fact that inorder to be employed by Sierra Spring Assisted Living. I will be required to undergo a Criminal History Screening within 20 days of employment. The	10/31/15

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A 016	Continued From page 3 approved program for assisted living administrators. Admin stated that she is just now doing the program for certification, is on module 4, and should complete the course by this weekend, which is "probably why I do not know all this stuff." C. On 08/11/15 at 4:45 pm, during interview Admin confirmed that she had not yet completed the program for Assisted Living Administrators. Findings related to the EAR/CCHSP: A. Record review of staff files revealed that staff (S #3) had a hire date of 12/05/06, however, her EAR clearance summary was dated 07/18/07, and her CCHSP clearance letter was dated 09/20/07. B. Record review of staff files revealed that S #4 had a hire date of 11/22/06 (per Admin), however, her EAR clearance summary was dated 02/05/08, and her CCHSP clearance letter was dated 01/22/07. C. Record review of staff files revealed that S #5 had a hire date of 05/14/15, however, her EAR and CCHSP application was not submitted by the facility until 08/04/15 after the administrator was informed by the Licensing Authority and directed to contact CCHSP for direction. D. Record review of staff files revealed that S #7 had a hire date of 07/02/15, however, her EAR and new CCHSP application (previous clearance for different employer was dated 04/25/15 was not submitted by the facility until 08/04/15 after the administrator was informed by the Licensing Authority and directed to contact CCHSP for direction.	A 016	CCHSP will be completed at the time each new employee picks up their first pay check.	10/31/15

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A 016	Continued From page 4 E. Record review of staff files revealed that S #8 had a hire date of 07/19/15, however, EAR was not submitted by the facility until 08/04/15 after the Admin was informed by the Licensing Authority and directed to contact CCHSP for direction. Her CCHSP Authorization to Release Information was not signed until 08/06/15. F. Record review of staff files revealed that S #9 had a hire date of 07/15/09, however, his EAR summary has a date of 05/15/11, and his CCHSP clearance letter has a date of 03/24/11. G. On 08/07/15 at 12:31 pm, during interview with Admin, she confirmed that the EAR and CCHSP had not been completed as required by regulation.	A 016		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food;	A 017	In order to correct the violation of failing to ensure that caregivers were properly trained to perform an appropriate 2 person transfer for 1 person/resident all caregivers will attend a training on transfers The training will include the discription	

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A 017	Continued From page 5 (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to paragraph 7.8.2. 17 C (9) Based on record review, observation and interview, the facility failed to ensure that caregivers were properly trained to perform an appropriate 2 person transfer for 1 resident (R #8) of 1 (R #8) reviewed for skin injuries during transfers. This deficient practice resulted in actual harm to R #8 in the form of bruising, skin tears, and wounds. The findings are: A. Record review of Home Health Agency	A 017	of how to transfer, pictures of each step of the transfer, and a demonstration of transferring. Each caregiver will also perform the transfer in order to ensure ongoing compliance of resident transfers. This training program will be included in the orientation and yearly training. It will be listed on the orientation agenda form and on the yearly training agenda form. 10/31/15	

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A 017	Continued From page 6 Records revealed the following. 1. A note written by Home Health Nurse #1 (HHN #1) dated 06/29/15 states, "Administrator made aware of writer's concern regarding pressure ulcer to elbow as well as proper positioning of patient in her wheelchair. Patient was found to also have large skin tear to left upper extremity. Patient, spouse, and administrator were educated on proper transfer techniques to try to promote safe transfers and decrease risk of injury." 2. A note written by HHN #1 dated 07/16/15 states, "Writer viewed assisted living facility (ALF) staff transferring patient improperly. Writer discussed with staff, patient, and spouse safe transfer techniques to try to minimize further skin tears to upper extremities." 3. A note written by HHN #1 dated 07/20/15 states, "Patient was found to have a large skin tear to her right posterior upper arm. Writer discussed previous concerns regarding staff knowledge and skill set when caring for a more acute patient who requires a 2 person transfer and more care than the average ALF patient. Administrator aware of writer's concerns. This is the 5th skin tear since writer has begun seeing patient. Writer has multiple concerns with the quality of care as well as the lack of staff training and supervision at the ALF facility. Writer attempted to discuss concerns with administration but no changes have been made that writer can see." 4. A note written by HHN #1 dated 08/01/15 states, "Writer is concerned as patient is a 2 person transfer with full assistance needed. ALF staff is using small sliding board to help transfer.	A 017		

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A 017	Continued From page 7 Writer discussed with ALF staff proper transfer techniques as patient cannot support her core and upper body to properly transfer on sliding board. Patient is otherwise stable and doing well at the time of the assessment." B. On 08/04/15 at 10:00 am, during interview, Home Health Nurse #2 (HHN #2) stated, "Several nurses and therapists have expressed concern that when they go to see the residents, there are no staff around. [Name of HHN #1] visits her 3 times per week on Monday, Wednesday, and Friday. The staff is incorrectly transferring her. That is what is causing skin tears. The facility does not have a nurse." C. On 08/04/15 at 11:00 am, during interview, caregivers S #3 and S #4 stated that up until a month ago, they were transferring R #8 without the board. R #8 would rub against her wheelchair or the tires, and that would cause skin tears. S #3 stated, "We always use a 2 person transfer with a transfer board. The skin tears are caused when she gets pinched between the arm rest and the back of the wheelchair. The wheelchair was purchased when she entered the facility. Before the use of the board, the firemen's carry was used to transfer her. The nurse wanted to ensure that no one touches her arms. We have been trying to order a new wheelchair but have been unsuccessful." D. On 08/04/15 at 1:30 pm, during observation, the surveyor noted that transfer from wheelchair to bed was performed by 2 caregivers. The wheelchair was put into a position perpendicular to the bed and brought up against the bed. One caregiver moved behind her. The other caregiver moved a board under her legs. Together, the caregivers moved her from the wheelchair to her	A 017		

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A 017	Continued From page 8 bed without grabbing her arms. E. On 08/05/15 at 10:15 am, during interview, HHN #1, stated, "One of the concerns is that R #8 has 6 skin tears on her arms. We were initially called for a skin tear on her right elbow. In reality, it was a stage 3 pressure ulcer. The dressing is covering the pressure ulcer. Right above that is another dressing that covers an additional skin tear. This is the 5th or 6th skin tear in the past 2 months. The Administrator assured me that they were transferring her correctly. That is not true, because half the time I have been there I sat in the room and watched 2 of the aides transfer R #8 by picking her up by the arms, the wrong way to transfer someone. There are no clinical people here to train the caregiver staff." F. On 08/05/15, HHN #1 submitted a witness statement form attesting to what he observed regarding the nature of R #8's wounds and the facility process of transferring her. G. On 08/10/15 at 1:30 pm, during interview, HHN #1 said that he did not train the facility staff to use the transfer board that they use. He said that he felt that the board was inappropriate. He said that the proper way to transfer R #8 is to first remove the wheelchair arm. Then, one caregiver would get behind her and hold her under the arms while the other caregiver would hold her under her legs. Together they would move R #8 onto the bed. H, On 08/10/15 at 2:20 pm, during interview, the Administrator, she stated that the staff of the nursing home from which R #8 came to the ALF showed her how to transfer, lifting the resident from under her arms and legs and setting her on her bed. She did not like that mode of transfer.	A 017		

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A 017	Continued From page 9 HHN #1 did not like this method either. He wanted her to be transferred without holding her arms. The Administrator then taught the caregivers how use the sliding board. The process is as follows. 1. Take off the arms of the wheelchair. 2. Slide the board underneath R #8's bottom and cross onto the bed. 3. One caregiver would be on the right side holding her sweats. The other would be on the left side holding her sweats. Then they would slide her across the bed. The Administrator said that she trained all caregivers in this method. She stated that the skin tears occurred when R #8 became angry and would throw a tantrum. She would move forward and backward and slam her body against the wheelchair. She would also lean from one side to the other. Her pressure ulcer was caused by her elbow rubbing against a metal plate on the wheelchair. R #8 had received the wheelchair when she arrived at the facility. The Administrator agreed that this was an inappropriate admission from the start. I: On 08/10/15 at 3:40 pm, during interview, Caregiver (S #5) stated, "We used to pick her up with one hand on her pants and the other under her arm. Then we would transfer her. We were told we had to transfer her a different way because by picking her up by the arms, her skin was tearing. What we do now is get the board, lift one side of her butt, and slide the board under her. The board would be half under her and half on the chair. Then with 1 caregiver on each side of her, we pick her up by the pants at the seam and slide her around. The skin tears have stopped since this process was implemented. The pillow helps with the pressure ulcer. After her transfer to the wheelchair, we picked up her arm, put the arm rest down, and put a pillow on the arm rest so her arm would not be in direct	A 017		

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A 017	Continued From page 10 contact with the chair, under pressure. I was not given formal training in patient transfer techniques but was trained by other caregivers."	A 017	In order to correct the violation of failing to maintain complete, organized, and accessible records individual binders with tabs specifying the contents of each section will be compiled for each resident. All of the required records will be kept in each residents' binder. The binders will be kept in the medication closet to provide easy access. In order to ensure that our records are maintained according to the state regulations the resident binders	
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph;	A 021		

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A 021	Continued From page 11 (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) 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; (7) entries by direct care staff, appropriate health care professionals and 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 ISP; (8) entries that provide 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 documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the	A 021	will be reviewed on the third Tuesday of each month. The review will consist of evaluation of each section of each binder. The binders will be evaluated for completion dates, all required documents and review of progress notes completed by Contract agencies. Staff entries will also be reviewed including review of the section that requires a written account of all accidents, injuries, illnesses, medical and dental appointments,	

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SIERRA SPRINGS ASSISTED LIVING	503 LOS LENTES ROAD NE LOS LUNAS, NM 87031

(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 021	Continued From page 12 information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 021	and problems or improvements observed in the residents, and any condition that would indicate a need for alternative placement or medical attention. 10/31/15	

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A 021	Continued From page 13 This deficiency refers to paragraph 7.8.2.21 A and B Based on record review and interview, the facility failed to maintain complete, organized, and accessible records for 5 (R #2, 3, 5, 7 and 8) of 5 sampled residents identified by the Administrator (Admin) on 08/04/15 from the resident census, as receiving home health services and/or Warfarin (blood-thinner) use. If resident records are not accurate, complete, organized, and accessible then needed critical medical information required by staff and healthcare professionals may not be available when medication and healthcare decisions need to be made. The findings are: A. Record review of resident files for R #2, 3, 5, 7, 8 revealed that the facility does not have individual resident charts with all the required documents. B. Record review of resident files for R #2 revealed the following: 1. Per admission agreement, R #2 was admitted on 03/17/12. Resident's Individual Services Plan (ISP) has an admission date of 07/01/11, a completion date of 10/15/11, three months after admission, and reviewing nurse signed and dated on 11/07/11. 2. The resident evaluation has evaluation dates of 10/15/11, 05/09/12, 12/28/12, and 08/01/13. The first evaluation was not completed prior to admission and the last evaluation date was 2 years ago. 3. There were no entries by healthcare professionals or others authorized to care for resident.	A 021		

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A 021	Continued From page 14 4. There were no written accounts of any 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- 5. There were no progress notes completed by any contract agency (e.g., hospice, home health). C. Record review of resident files for R #3 revealed the following: 1. Per admission agreement R #3 was admitted on 08/08/14, with an evaluation date of 08/08/14. The evaluation was not signed by the reviewing nurse. There were no further documented evaluations. 2. There was no ISP in resident file. 3. There were no entries by healthcare professionals or others authorized to care for resident. 4. There were no written account of any 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. 5. There were no progress notes completed by any contract agency (e.g.,hospice, home health). D: Record review of resident files for R #5 revealed the following:	A 021		

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A 021	Continued From page 15 1. Per admission agreement, R #5 was admitted on 06/29/12. Initial evaluation was dated 06/29/12, the last evaluation was dated 03/10/14. 2. There was no ISP in file. 3. There were no entries by healthcare professionals or others authorized to care for resident. 4. There were no 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. 5. There were no progress notes completed by any contract agency (e.g., hospice, home health). E. Record review of resident files for R #7 revealed the following: 1. Admission agreement was not completed until 08/04/15. Per admission agreement R #7 was admitted on 03/06/15. 2: There was no evaluation or ISP in the file. 3. There were no entries by healthcare professionals or others authorized to care for resident. 4. There were no 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	A 021		

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A 021	Continued From page 16 medical attention and entries reflecting appropriate follow-up. 5. There were no progress notes completed by any contract agency (e.g., hospice, home health). F. Record review of resident files for R #8 revealed the following: 1. Per admission agreement R #8 was admitted on 01/02/15. Initial and only evaluation was completed until 01/03/15 after admission. 2. There were no entries by healthcare professionals or others authorized to care for resident. 3. There were no 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. 4. There were no progress notes completed by any contract agency (e.g., hospice, home health). G. On 08/05/15 at 10:50 am during interview with Admin. she confirmed that there are no progress notes in any of the residents charts. Admin says she did not know the Home Health/Hospice/Physicians/etc should be charting visits. They (providers) just tell her or staff what is going on with residents. Staff does not document conversations. H. On 08/05/15 at 2:30 pm, during interview with Admin, she confirmed that all the resident files records are incomplete and do not include all	A 021		

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A 021	Continued From page 17 required documents are not maintained in an organized, accessible, and permanent manner. Admin confirmed that the copies provided were what was in their charts, and an accurate account of what had/had not been done for the resident. Admin stated that she has had a hard time keeping up or staying organized the last few years as the residents acuity and care needs increased. I. On 08/11/15 at 8:08 am, during interview with R #5's physician he stated that there needs to be some kind of accountability by the facility. They need some way of getting orders processed correctly. Ideally, having a resident chart with duplicate forms for doctors and providers to complete when visiting. Currently, when he visits he does not have access to the residents' chart/medical records and leaves new orders with staff or in the mailbox on Admin's door, but is not sure if they get processed correctly. J. On 08/11/15 at 11:22 am, during interview with Consultant Pharmacist, stated that when she does her reviews, she does not have access to all the residents information or resident charts.	A 021		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six	A 025	In order to correct the violation of not completing the resident evaluations within 15 days prior to admission we will complete the resident evaluation form	

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A 025	Continued From page 18 (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time	A 025	within 15 days prior to admission of any new residents. To ensure that a resident evaluation is completed 15 days prior to admission of a new resident our facility will not except a new admit until the new admits resident evaluation form is in the new admits folder. In order to correct the violation of not completing a review and update of the residents evaluations every 6 months or when there is a significant change a resident evaluation	10/31/15

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A 025	Continued From page 19 the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 A and B Based on record review and interview the facility failed to ensure that resident evaluations were: 1: Completed within 15 days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. 2: Reviewed and updated at a minimum of every 6 months or when there is a significant change in resident's health status. 3: Reviewed and if needed revised by a licensed practical nurse (LPN), registered nurse (RN), or a physician extender (PE) at the time the Individual Service Plan (ISP) is reviewed. If the evaluations are not completed prior to admission or reviewed at a minimum of every 6 months by a LPN, RN, or PE then all 5 (R #2, 3, 5, 7, and 8) sampled residents identified by the Administrator (Admin) on 08/04/15 from the resident census, as receiving home health services and/ Warfarin (blood-thinner) use are at risk of the staff not being able to provide the level of assistance needed after admission, adjust care provided as residents level of assistance needs change, and provide improper care if level of assistance needed has not been reviewed by a LPN, RN, or PE. The findings are:	A 025	was completed for all of our residents in August of 2015. In order to ensure that the resident evaluations are reviewed every six months or when there is a significant change the resident's evaluations will be reviewed on the third Tuesday of every month to determine if there is a change in the residents condition and also to determine 1 month prior to the 6 month review requirement to contact the	

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A 025	Continued From page 20 A. Record review of resident evaluation forms for R #2 and 8 revealed that the initial evaluations were not completed prior to admission. B. Record review of resident evaluation forms for R #7 revealed no documentation of an evaluation being completed prior to admission. C. Record review of resident evaluations revealed that six month evaluation reviews had not been completed for all 5 sampled residents. D. Record review of resident evaluation forms for R #2 and R # 8 revealed the reviewing nurse staff (S #2) is not a LPN/RN/PE. E. Record review of resident evaluation form for R #3 revealed the initial evaluation dated 08/08/14 was not signed by a reviewing nurse. F. Record review of resident evaluation form for R #5 revealed only a partial (missing pages) evaluation form, the reviewing nurse signature page was missing. G. On 08/04/14 at 1:50 pm, during interview with Admin she stated that the the contracted person S #2 who has been reviewing the resident evaluations and ISP's for the facility for approximately the last 2 years has a 4 year Nursing Degree from University of New Mexico but is not a licensed nurse. H. On 08/04/15 at 2:00 pm, during interview with the reviewing nurse S #2, she confirmed that she is not a licensed nurse I. On 08/05/15 at 2:20 pm, during interview with Admin, she confirmed the evaluation findings for	A 025	RN to schedule a review one month prior to the due date 10/31/15	

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A 025	Continued From page 21 a 5 sampled residents, that the resident files were disorganized, and incomplete. Admin stated that she has not been keeping up and staying organized the last few years as the resident's acuity has increased.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to 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) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident;	A 026	In order to correct the violation of not ensuring that the Individual Service Plans were being developed and implemented within 10 days of admission an Individual Service Plan will be developed within 10 days of admission for all new residents. In order to ensure that there is ongoing compliance to this regulation during the record review of all our residents records	

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A 026	Continued From page 22 (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (1), (2) (3) Based on record review and interview the facility failed ensure: 1. That Individual Service Plans (ISP) were being developed and implemented within 10-days of admission. 2. That the ISP details the services that are provided by other agencies. 3. That the ISP is reviewed and if needed revised by a licensed practical nurse (LPN), registered nurse (RN) or a physician extender (PE). 4. That the ISP are reviewed or revised at a minimum of every 6 months or when there is a significant change in the resident's health status. If the ISP's are not developed or reviewed as required by regulation, then the 5 (R #2, 3, 5, 7, 8) sampled residents identified by the Administrator (Admin) on 08/04/15 from the resident census, as receiving home health services and/or Warfarin (blood-thinner) use are at risk of the staff not knowing what resident care is needed on admission, able to adjust care when resident needs change, or provide the wrong care if the ISP has not been reviewed every six	A 026	which commences on every third Tuesday of the month. The ISPs for all new admits will be reviewed to ensure that an ISP is completed during the 10 days after admission. In order to correct the violation of not ensuring that the ISP details the services provided by outside agencies the ISPs were reviewed and changed for those who were on with a home health care agency. In order to ensure continued	

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A 026	Continued From page 23 months by a LPN, RN, or PE. The findings are: Findings related to ISP's and coordination of care with outside agencies. A. Record review of resident files for R #2 revealed: 1. R #2 was admitted on 07/01/11. An initial ISP was not completed until 10/15/11. 2. The ISP for R #2 did not reflect the home health services that she is receiving from an outside agency or what type of care or services they are providing. 3. The ISP was signed by staff (S #2) who is not a LPN/RN/PE B. Record review of resident files for R #3 revealed: 1. R #3 was admitted on 08/08/14. There was no documentation of an ISP in her file. 2. The ISP for R #3 did not reflect the home health services that she is receiving from an outside or what type of care or services they are providing. C. Record review of resident files for R #5 revealed: 1. R #5 was admitted on 06/29/12, however, there was no documentation of an ISP in her file. 2. The ISP Review sheet revealed that an ISP was last reviewed 09/15/14. 3. The ISP Review sheet was signed by S #2, who is not a LPN/RN/PE. D. Record review of resident files for R #7 revealed: 1. R #7's was admitted 03/06/15, however, there was no ISP found in file. 2. There was no documentation of coordination of care with the outside home health agency that	A 026	compliance during the records review that will take place every third Tuesday of the month. The ISPs will be reviewed and changed to reflect a discharge, or getting on with an outside agency. In order to correct the violation of not having a nurse review the ISPs every 6 months we are contracted with an RN who agreed to come in every 6 months and for new admits to review our ISPs. The RN	

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A 026	Continued From page 24 is providing her home health services. E. Record review of resident files for R #8 revealed: 1. R #8 was admitted on 01/02/15 however, an initial ISP was not completed until 01/14/14. 2. The ISP does not identify resident as a 2-person transfer. 3. The ISP has not been updated to reflect the home health services that she is receiving from an outside agency or what type of care or services they are providing. 4. There was no documentation of any ISP reviews since 01/14/14. 5. The person, S #2, who signed the ISP's is not a LPN/RN/PE. F. On 08/05/15 at 2:20 pm, during interview with Admin, she confirmed ISP findings for each sampled resident, that the resident files were disorganized, and incomplete. Admin stated that she has not been keeping up and staying organized the last few years as the resident's acuity has increased. Findings related to non-licensed nurse. A. Record review of staff files revealed no documentation that S #2, the person hired by the facility to review resident evaluations and ISP's was a licensed practical nurse, registered nurse, or a physician extender. B. On 08/04/15 at 1:50 pm, during interview with Admin she stated that S #2, the person who has been reviewing the resident evaluations and ISP's at the facility for approximately the last 2 years has a 4 year Nursing Degree from University of New Mexico, but is not licensed at this time. C. On 08/04/15 at 2:00 pm, during interview, S	A 026	was advised that if there is a significant change in a residents health status the ISP must reflect that change. 10/31/15	

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A 026	Continued From page 25 #2 confirmed that she is not a licensed nurse. D. Record review of resident files for R #2 revealed that the person signing as the reviewing nurse on the for ISP Review Sheet for dates of 01/31/13, 08/07/13, 03/10/14, 09/15/14. and 02/10/15 is not a Licensed Practical Nurse (LPN), Registered Nurse (RN), or Physician Extender (PE). E. Record review of the ISP Review Sheet for R #5 for review dates of 01/31/13, 08/07/13, 03/10/14, and 09/15/14 revealed that the person signing as the reviewing nurse is no a LPN/RN/PE. F. Record review of resident files for R #8 revealed that the person signing the ISP dated 01/14/15 as the reviewing nurse is not a LPN/RN/PE. There was no documentation that the ISP had been reviewed since 01/14/15. Finding related to ISP's not being reviewed at a minimum of every 6 months. A. Record review of ISP Review Sheet for R #5 revealed the last review date was 09/15/14. B. Record review ISP for R #8 revealed the last documented ISP review was on 01/14/15. C. On 08/05/15 at 2:20 pm, during interview with Admin, she confirmed each of the ISP findings for each resident and that the resident files were disorganized and incomplete. Admin stated that she has not been keeping up and staying organized the last few years as the resident's acuity has increased.	A 026		

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A 033	Continued From page 26	A 033		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all	A 033		

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A 033	Continued From page 27 services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are	A 033		

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A 033	Continued From page 28 informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 033		

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A 033	Continued From page 29 7.8.2.33 D (11) (a) On 08/11/15 at 9:34 am, an Immediate Jeopardy (IJ) was called for 1 (R #5) of the 4 (R #2, 3, 5, 8) sampled residents for Warfarin/Coumadin medication use, identified from the resident census, provided by the Administrator (Admin) on 08/04/15 for neglect due to the facility not ensuring that she was getting her PT/INR (blood level checks) as ordered. the facility knew that R #5 was taking Warfarin/Coumadin (blood thinning) medication. Because R #5 did not have her blood levels checked as ordered her Primary Care Physician (PCP) was not able to make medication adjustments, based on the test results which increased her risk for excessive bleeding or stroke. The findings are: On 08/11/15 at 4:16 pm, a plan of removal was accepted from the facility Administrator, which included the following: A. When a resident is prescribed a blood thinner they will be listed on the "Resident on Blood Thinner" form. B. The form will list the person's name, the agency performing the blood thinner draws, there phone number, the current dose/date, and the date the INR must be rechecked. C. The form will be reviewed every Wednesday by the administrator. D. the administrator will verify that the current blood thinner orders are in the resident's charts. E. The administrator will verify that the resident had transportation to the get the blood draw. F. No changes will be made to the medication reorders without a signed doctors order G. If a home healthcare nurse is performing the draws, she will be required to document in the resident's chart under "Outside Agency Services"	A 033	In order to, correct the violation of not ensuring that the residents on blood thinners were getting their blood levels checked on time a blood thinner schedule was created. when a resident is prescribed a blood thinner they will be listed on the "Resident on blood thinner" form. The form will list the person's name, the agency performing the blood thinner draws, there phone number, the current dose/date, and the date the INR must be rechecked. The form will be reviewed every Wednesday by the administrator. The administrator will verify that the current blood thinner orders are in the	

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A 033	Continued From page 30 the services provided. Home healthcare nurses are also to write in the new blood thinner orders on the Coumadin Orders sheet and sign. H. Faxed orders and orders that are brought in will be documented on the resident's Coumadin Orders sheet. All orders will be kept in the resident's chart. Based on record review and interview the facility failed to ensure the health and safety of 3 (R #2, 3, 5) of 4 (R #2, 3, 5, 7) residents sampled for Warfarin/Coumadin medication use, identified on the Resident Census, by the Administrator on 08/04/15. If residents who are taking Warfarin/Coumadin do not have their blood check regularly and the medication adjusted based on the test results, puts them at risk of harm or possibly death due to excessive bleeding or clotting causing a stroke. The findings are: A. On 08/11/15 at 11:22 am, during interview with Consultant Pharmacist, she stated that for residents taking Coumadin/Warfarin it is important that their blood levels are checked regularly because if the resident's blood level is too high they are at risk of bleeding, if the blood level is to low they are at risk of clotting and possible stroke. Findings related to R #2. A. Record review of Coumadin/Warfarin Dosing Order's form revealed no documentation of medication changes for R #2 from 01/31/15 to 07/14/15. B. On 08/04/15 at 11:20 am, during interview with R #2 she stated that home health was doing her PT/INR blood checks, then they stopped, now they are doing them again.	A 033	residents charts. The administrator will verify that the resident has transportation to get to the blood draw. If a home healthcare nurse is performing the draws, she will be required to document in the residents chart the new dose order. Faxed orders and orders that are brought in will be documented on the resident's Coumadin Order sheet. Any new residents on blood thinners will receive this same service for their INR and dosing orders. 8/11/15	

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A 033	Continued From page 31 C. On 08/10/15 at 3:05 pm, during interview with Admin, she confirmed that R #2's PT/INR blood checks's did not get done after Home Health discharged the resident and discontinued doing the testing. D. On 08/11/15 at 8:08 am, during interview with Primary Care Physician (PCP), he confirmed that according to his records, R #2 went from January 2015 to July 2015 without having her PT/INR blood checks done. A home health agency is now doing R #2's PT/INR blood checks. Finding related to R #3. A. Record review of resident files for R #3 revealed no documentation that R #3 had been having her PT/INR blood checks done. B. On 08/04/15 at 2:32 pm, during interview with Admin, she confirmed that there was no documentation that R #3 had been having her PT/INR blood checks done. Admin stated that hospice/home health was doing the testing, then stopped in August 2014 when resident was discharged from services and then R #3's daughter was taking her in March 2015. Daughter is no longer able to take resident so resident has been placed on palliative care services and home health is now coming to do the blood checks. C. On 08/05/15 at 9:43 am, during interview with R #3's daughter, she stated that she did not realize that when her mother went off hospice services, that no one was still coming to the facility to do the blood checks. Daughter says she did not know that Warfarin/Coumadin needed to be monitored. D. On 08/05/15 at 12:10 pm, during interview	A 033		

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A 033	Continued From page 32 Hospice nurse (HN #1) she reported that Hospice has no record of R #3's PT/INR blood checks being done since August 2014 and restarted at Coumadin clinic on 3/25/15. She feels that the facility should have been aware that the Pt/INR's needed to be checked and aware of the potential harm. E. 08/10/15 at 3:05 pm, during interview with Admin, she confirmed that R #3's PT/INR's blood checks did not get done after Hospice/Home Health discharged resident and discontinued doing the testing. Findings related to R #5. A. Record review of physician's orders for R #5 revealed a standing order for PT/INR blood checks dated 01/16/15 thru 01/16/16 to be completed for Warfarin (blood thinner) monitoring as needed based on test results. B: Record review of resident's file revealed no documentation that R #5 had received any PT/INR blood checks. C: Record review of the Coumadin/Warfarin Dosing Orders form revealed that last order change for R #5 was documented was on 04/07/15 and read 4mg every day. D. On 08/10/15 at 1:37 pm, during interview with R #5 she stated that she was getting blood checked regularly, but not in a long time. She guessed they stopped it all together. When asked if she knew why they were checking her blood; R #5 said they would check her blood to make sure her levels were ok. E. On 08/10/15 at 1:47 pm, during interview with the Registered Medical Assistant (RMA) for	A 033		

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A 033	Continued From page 33 PCP she reported that the last recorded PT/INR blood checks at the PCP's office for R #5 was 05/04/15 which should have been rechecked in 2 weeks. In addition, she stated that the facility failed to respond to requests for a current medication list for R #5. F. On 08/10/15 at 3:05 pm, during interview with Admin, she confirmed that facility failed to coordinate care with the home health agency in May 2015 when the resident was discharged from services and the home health agency discontinued doing the PT/INR blood checks. Admin confirmed that R #5's PT/INR blood checks did not get done after home health discharged resident. Admin stated that she did not realize that home health had been discontinued until surveyor brought it to her attention. G. On 8/11/15 at 8:08 am, during interview with PCP, he stated that R #5 should have been having PT/INR blood checks done bi-weekly or weekly depending on the readings. Not having blood checks as ordered, puts the resident at risk for excessive bleeding or clotting causing a stroke. The facility failed to communicate with R #5's PCP in July 2015 when resident had bleeding and bruising incidents.	A 033		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in	A 034	In order to correct the violation of not having over-the-counter medications labeled with the residents name we labeled all over-	

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A 034	Continued From page 34 obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet	A 034	1) the - counter medications with the residents names. In order to assure ongoing compliance the medication cubbies will be inspected at the end of every month when the mars are being prepared for the upcoming month. all O-T-C medications will be labeled at that time if there are O-T-C medications with out labels. 2) In order to correct the violation of not having a physicians order deeming it appropriate for one	

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A 034	Continued From page 35 shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including	A 034	of our residents to self-administer her own medications we now have the order allowing self-administration of medication in her records. To ensure ongoing compliance with this regulation the doctor's order for self-administration of medication will be required at admission. The admission agreement will state; "A doctor's order is required for self-administration of medication" (3) In order to correct	

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A 034	Continued From page 36 reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (4) (5) (7) (9), B (1) Reference NFPA 99, 1999 Edition Section 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) * Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both) 1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin. 2. * Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations.	A 034	The violation of improper storage of oxygen cylinders all of our oxygen cylinders will be stored in a ventilated room in a non-mobile oxygen cylinder rack. In order to ensure ongoing compliance a sign will be attached to the rack that states, "All oxygen cylinders must be placed in this rack." (4) In order to correct the violation of having medications that were discontinued in a residents med. cubby. The residents cubbies were inspected to ensure that there	

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A 034	Continued From page 37 Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose. 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage. 5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [see also 4-3.1.1.2(a)7]. 6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat. 7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use. 9. Containers shall not be stored in a tightly closed space such as a closet [see 8-2.1.2.3(c)]. Based on record review, observation, and	A 034	were no discontinued medication in the residents cubbies. In order to ensure ongoing compliance the medication cubbies will be inspected for discontinued medication. The inspection will take place at the end of each month when the Mars for the upcoming month are being printed. 5) The violation of not having timely pharmacist audits will be corrected by contacting the pharmacist to schedule a time to complete	

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A 034	Continued From page 38 interview the facility failed to ensure for 4 (R #3, 5, 7, 8) of 5 (R #2, 3, 5, 7, 8) sampled residents, identified by the Administrator (Admin) on 08/04/15, from the resident census list for Warfarin (blood-thinner) use and self-administration of medication that: 1. all medications including over-the-counter (OTC) were labeled with the resident's name. 2. residents who store and self-administer their own medications had physician's orders deeming it appropriate. 3. oxygen tanks are stored in compliance with the National Fire Protection Association (NFPA) 99. 4. all medications discontinued by physician order were removed from the medication box. 5. That the consultant pharmacist conducts medication review quarterly This deficient practice has the potential to for residents to be harmed if: 1. Medications are not properly labeled to ensure they are only given to the resident they were ordered for. 2. Medications are taken incorrectly by a resident is who has not been deemed able to storing and self-administer medication by a physician. 3. Oxygen tanks fall over, break, and start leaking. 4. Medication is given in error after being discontinued by the physician because it is was not removed from the medication box. 5. Resident medications are not reviewed quarterly by the consultant pharmacist to insure accuracy and need for medical intervention. The findings are: Finding related to Medications not being labeled. A. On 08/11/15 at 12:10 pm, during observation	A 034	the audits that is due. In order to ensure compliance the audits will be set for quarterly reviews for designated months. The designated months for quarterly reviews will be set for: January, April, July, and October. The designated months that the pharmacist audits are due will be listed on the contract agreement between the pharmacist and the facility.	

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A 034	Continued From page 39 of R #5's medication box, a bottle of Tylenol 500mg (milligrams) was not labeled with the resident's name. B. On 08/11/15 at 12:30 pm, during interview, the House Manager (HM)verified that R #5's Tylenol was not labeled with the resident's name. C. On 08/11/15 at 1:35 pm, during observation of R #3's medication box, a bottle of Tylenol 500mg was not labeled with the resident's name. D. On 08/11/15 at 1:50 pm, during interview, the HM verified that R #3's Tylenol was not labeled with the resident's name. E. On 08/11/15 at 1:55 pm, during observation of R #8's medication box, a bottle of Vit D3-1000 and a bottle of Robitussin was not labeled with the resident's name. F. On 08/11/15 at 2:06 pm, during interview, the HM verified that R #8's bottle of Wit D3-1000 and a bottle of Robitussin were not labeled with R #8's name. Findings related to resident #7 storing and self-administering her own medications. A. On 08/05/15 at 8:15 am, during observation, R #7 was observed with her box of medications sitting on the table, in the dining room with a group of pills laid out. R #7 left the table for a period of time, leaving her medications on the table and in reach of other residents. B. On 08/05/15 at 8:15 am, during interview, staff (S #3) stated that R #7 takes her own medications. C. Record review of R #7's file revealed no	A 034		

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A 034	Continued From page 40 documentation from the physician that the resident had been deemed appropriate to store and self-administer her own medications. D. On 08/05/15 at 2:30 pm, during interview, the Administrator confirmed that there was not an order from R #7's physician deeming her appropriate to store and self-administer her own medications. The Administrator stated she was not aware that an order was needed. She stated that would prefer to have staff assist the resident, but the resident does not want assistance, and the resident's son said to let the resident take her own medications. Findings related to oxygen storage. A. On 08/06/15 at 8:31 am, during observation, 5 oxygen cylinder tanks were observed unsecured in R #7's room. B. On 08/06/15 at 9:15 am, during observation of the hall closet, oxygen cylinder tanks in a rack, 4-lg, 3-med, and 3-sm oxygen cylinder tanks not in a rack (1-lg in a plastic crate lying sideways with a large weight scale lying on top of it). This is a small storage closet which also houses a fire extinguisher and other combustible items. C. On 08/06/15 at 10:40 am, during observation with House Manager (HM) unsecured oxygen cylinder tanks were observed in R #7's room. In addition, multiple secured and unsecured oxygen cylinder tanks of various sizes were observed being stored in 2 unventilated closets. D. On 08/6/15 at 10:40 am, during interview with HM, he confirmed that 1. there were unsecured oxygen cylinder tanks were in R #7's room. 2. that multiple	A 034		

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A 034	Continued From page 41 secured and unsecured oxygen cylinder tanks were being stored in the closets and that the closets are not ventilated. HM stated that the oxygen cylinder tanks in the closets were empty tanks from a former resident and should be returned to the oxygen company. When asked how the oxygen cylinder tanks should be secured his response was "In a rack" and confirmed that the oxygen cylinder tanks were not secured properly. HM stated he was not aware that the oxygen cylinder tanks could not be stored in the resident's closet or in any unventilated closet/space. Finding related to discontinued medications. A. On 08/11/15 at 12:10 pm, during observation with HM of R #5's medication box it was observed that Potassium 1 10 mg which had been d/cd on 08/01/15 was still in medication box. B. On 08/11/15 at 12:30 pm, during interview the HM confirmed that R #5's Potassium 1 10 mg which had been dc'd on 08/01/15 was still in medication box. Findings related to Consultant Pharmacist reviews. A. Record review of the consultant pharmacist review log revealed that pharmacist reviews were not being completed quarterly, Review dates for the current current consultant pharmacist were 12/08/14 and 06/15/15. B. On 08/11/15 at 11:22 am, during interview with Consultant Pharmacist (CP), she confirmed the review dates of 12/08/14 and 06/15/15.	A 034		

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A 034	Continued From page 42 C. On 08/11/15 at 1:28 pm, during interview with Admin and HM confirmed the CP review dates of 12/08/14 and 06/15/15 and that the reviews had not been completed quarterly.	A 034		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. 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 from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the	A 035		

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A 035	Continued From page 43 number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name;	A 035		

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A 035	Continued From page 44 (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the	A 035		

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A 035	Continued From page 45 resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 A, G (2) Based on record review, observation and interview the facility failed to ensure for 4 residents (R #2, 3, 5, 8) of 4 (R #2, 3, 5, 8) reviewed for Warfarin/Coumadin use: 1. had current and correct physician orders for all medications, including over the counter (OTC) and PRN (when needed) medications 2. that the Medication Administration Record	A 035	(1) In order to correct the violation of not having current and correct physician orders for all medications. A current doctor's orders list will be requested for all	

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A 035	Continued From page 46 (MARS) was correct and included all required documentation. If there are not current and correct physician orders on file and if the MAR's are not complete with all necessary information then residents are at at risk not getting the correct medications in the correct doses. Staff, physicians, and other health care professional will not have current or correct information in case of an emergency or when making changes to residents medication. The findings are: Findings related to physician orders for R #2. A. Record review of physicians orders and MAR's for R #2 revealed there were no physicians orders for medications listed on the August 2015 MAR. B. On 08/07/15 at 3:00 pm, during interview with Administrator (Admin), she confirmed the missing physicians orders for R #2. C. On 08/11/15 at 12:45 pm, during observation of R #2's medication box the medication bottle read Cardvedilol 25 milligram, take one tablet by mouth twice daily. D. Record review of the the August 2015 MAR states Cardvedilol 25mg, take 1/2 twice daily. E. On 08/11/15 at 12:45 pm, during interview with Admin confirmed there were no physician orders for the change in dose. F. On 08/11/15 at 12:45 pm, during observation of R #2's Butt Paste and Lactulose solution were observed in R #2's medication box. There were no physician orders for the medications.	A 035	of our residents. -In order to ensure ongoing compliance a review of all orders for our resident will be conducted every third Tuesday of every month. -If at that time there are outdated doctor's orders new orders will be requested from the physician and will be placed in the resident's records. 2-In order to correct the violation of not having the required documentation on the Mar. The mars will	

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A 035	Continued From page 47 G. On 08/11/15 at 12:45 pm, during interview with Admin confirmed there were no physician orders for the Butt Paste and Lactulose solution. H. Record review of Coumadin/Warfarin Dosing Order sheet for R #2 revealed that R #2 should be receiving 4 mg (Monday and Wednesday) and 2 mg (Sunday, Tuesday, Thursday, Friday, and Saturday); there was no date or physician's signature on the order sheet. I. On 08/11/15 at 1:28 pm, during interview with Admin and House Manager (HM), Admin confirmed that she who is not a nurse or other licensed health care professional and she has been taking phone orders from the physicians and documenting them on the MAR's. Both Admin and HM confirmed the above findings. Findings related to physician's orders for R #3. A. Record review of physicians orders for R #3 revealed a physician's order dated 07/29/15 states Trazodone 12.5 mg, 1/2 tab 2x (times)'s daily. The MAR's states 50 mg, 1/2 tablet 2x's daily. There were no physician orders found to reflect the changes. B. Record review of physician orders dated 08/15/14 states; Lorazepam 1 mg tablet 1/2 to 1 tablet every 2hrs (hours) as needed for anxiety. The MAR's state; 0.5mg PRN (as needed), take 1 and 1/2 tablets twice a day for anxiety. There were no physician orders to reflect the changes. C. Record review of resident's physician orders dated 07/29/15 state; Furosemide 10 mg, take 1/2 tablet every other day. The MAR's state Furosemide 20 mg, take 1/2 tablet every other day. There were no physician orders found to	A 035	be revised to include the missing inputs. The new mar will be used for all of our residents and the missing information will be inputted.	

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A 035	Continued From page 48 reflect the changes. D. Record review of physician's orders dated 08/15/14 and 07/29/15 revealed no order for the POR-CHLORIDE 10meq (milliequivalent), take 1 tablet every other day that was listed on the MARS. E. Record review of R #3's August 2015 MAR revealed that revealed she was receiving POR-CHLORIDE 10meq (milliequivalent), take 1 tablet every other day. F. Record review of physician orders dated 07/29/15 included Lactulose 20g (grams), Calcium Carbonate, Asprin 325mg, and Pyhto-Estrogen that were not listed on the MAR. G. Record review of R #3's August MAR revealed no documentation of Lactulose 20g (grams), Calcium Carebonate, Asprin 325mg, and Pyhto-Estrogen to match the physician's orders. H. On 08/11/15 at 1:45 pm, during observation a bottle of Tylenol 500mg was in R #3's medication box, Tylenol was not listed on the MAR or on the physician's orders dated 08/15/14 or 07/29/15. I: On 08/11/15 at 1:50 pm, during interview with HM, he confirmed the above medication, physician orders and MAR's for R #3. Findings related to physician orders for R #5. A. Record review of physicians orders for R #5 revealed a standing order for PT/INR (a blood test used to monitor blood clotting factors) dated 01/16/15 thru 01/16/16 to be completed as needed based on test results so the physician	A 035		

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A 035	Continued From page 49 can make adjustments to her Coumadin/Warfarin (blood thinner) medications. B. Record review of resident's file revealed no documentation that R #5 had received any PT/INR labs tests. C. Record review of the facility Coumadin/Warfarin Dosing Orders form dated 04/07/15 revealed an order to take 4 mg every day. D. On 08/10/15 at 1:37 pm, during interview with R #5 she stated that she was getting blood checks regularly, but not in a long time. She guessed they stopped it all together. When asked if she knew why they were checking her blood she said to make sure her blood levels were ok, "They need to know it is ok". E. On 08/10/15 at 1:47 pm, during interview with the Registered Medical Assistant (RMA) for R #5's Primary Care Physician "PCP", she reported that the last recorded PT/INR checks at the PCP's office for R #5 was 05/04/15, which should have been rechecked in 2 weeks. RMA stated that as of 05/15/15, R #5's Warfarin dose was changed from take 4 mg every day to 3mg and 6mg alternate days so she has been receiving the incorrect dose since 05/04/15. F. On 08/10/15 at 3:05 pm, during interview with Admin, she confirmed that R #5 had not been having her blood levels checked since Home Health discontinued services in May 2015. Admin stated she was not aware that Home Health had been dc'd until surveyor brought it to her attention. Admin confirmed that she was not aware that resident had a test done in May 2015 at which time Warfarin dosage was changed, and she is currently receiving an incorrect dose.	A 035		

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A 035	Continued From page 50 Findings related MAR's A. Record review of R #2's July 2015 MAR's for R #2 revealed: 1. there was no documentation of R #2's allergies to Penicillin and Sulfa Drugs that were documented on evaluation form and ISP. 2. there was no diagnosis or reason listed for Timolol, Lisinopril, Latanprost, Mucinex, and Multi-Vitamins. B. Record review of R #3's August 2015 MAR revealed: 1. there was no documentation of R #3's allergy to Fosamax that was documented on the evaluation form. 2. there was no name of resident's PCP listed on the MAR. 3. resident has an order for PhytoEstrogen and Tylenol that were not listed on the MAR. 4. there were no diagnosis or reason listed for Trazodone, Warfarin, Furosemide, and Pot-Chloride. 5. Loramepam was not noted to be a scheduled II-IV drug. 6. there were not signatures of the staff who assist with medications on the MAR. 7. there was no documentation of desired results obtained or problems encountered with any medications including PRN Lorazepam 0.5 signed as given each morning 08/02/15 thru 08/10/15. 8. that on 08/03/14 and 08/04/15 resident's MAR for Warfarin is blank and there is no documentation as to whether resident received the medication or not. 9. that on 08/05/15 and on 08/06/15 the resident's MAR for Warfarin is signed as not-given, but there in no reason noted.	A 035		

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A 035	Continued From page 51 C. Record review of R #5's August 2015 MAR revealed: 1. there was no name of resident's PCP listed on the MAR. 2. there was no diagnosis or reason listed for Warfarin, Amlodipine, Lovastatin, KLO-CON, and Furosemide. 3. there no brand/generitc names for medications listed on MAR. 4. there was no route or method of delivery listed for Warfarin. 5. there were no signatures of staff who were assisting with medications. 6. on 08/01/15 thru 08/03/15 the MAR's is signed as not-given, but there is no reason noted. 7. on 08/04/15 the resident's MAR for Furosemide is blank and there is not documentation as to whether or not the resident received the medication. D. Record review of R #8's August 2015 MAR revealed: 1. there was no physician's name listed on the MAR. 2. there were no diagnosis or reason listed for Citalopram, Haloperidol, Tabavite, Vitamin D, Lovastin, Metoprolol, and Warfarin. 3. there no brand/generic names for medications listed on MAR. 4. schedule II-IV drug were not identified. . 5. there were no signatures of the staff who were assisting with medications. 6. Tabavite was not given on 08/05/15, no reason noted. 7 Metoprotol: Dosage changed or corrected, no date of change or by whom. 8. Vit D: Not given on 08/2, 3, 4, 5 and 7/15. No reason noted. E. 08/11/15 at 2:06 pm, during interview with HM, he confirmed the above MAR findings for R #2, 3, 5, and 8.	A 035		

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A 043	7 NMAC 8.2.43 Hazardous Areas HAZARDOUS AREAS: Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than one hundred (100) sq. ft., storage rooms more than fifty (50) sq. ft. but less than one hundred (100) sq. ft. not storing combustibles, storage rooms with more than one hundred (100) sq. ft. storing combustibles, chemical storage rooms with more than fifty (50) sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either: (1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter (3/4) hour rating; or (2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or (3) other hazardous areas shall be enclosed with walls with at least a twenty (20) minute fire rating and doors equivalent to one and three-quarter (1 3/4) inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. Boiler, furnace or fuel fired water heater rooms. For facilities with four (4) or more residents: 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 (1) hour. Doors to these rooms shall be one and three-quarter (1-3/4) inch solid core. [7.8.2.43 NMAC - Rp, 7.8.2.44 NMAC, 01/15/2010]	A 043		

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A 043	Continued From page 53 This REQUIREMENT is not met as evidenced by: Reference NFPA 99, 1999 Edition Section 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) * Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both) 1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin. 2. * Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose. 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in	A 043	In order to correct the violation of not storing oxygen cylinders according to the regulations for proper storage a non-mobile rack will be installed in a ventilated room. The rack will only be used for storing oxygen cylinders. In order to ensure compliance a sign will be posted on the rack that states, "All oxygen cylinders may only be stored in this rack." In order to correct the violation of not having oxygen in use signs posted	

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A 043	Continued From page 54 fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage. 5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [see also 4-3.1.1.2(a)7]. 6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat. 7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use. 9. Containers shall not be stored in a tightly closed space such as a closet [see 8-2.1.2.3(c)]. Based on observation and interview the facility failed to ensure that the medical gases (oxygen) tanks for 1 resident (R #7) of 1 (R #7) resident reviewed for oxygen use had an "Oxygen in Use" warning sign posted, and that cylinders belonging to former residents were stored in compliance with the national fire protection association (NFPA) 99. Oxygen cylinders are highly pressurized vessels and mismanagement could result in accidental discharge, which presents the risk of potential harm to all 15 (R #1-15) identified on the resident census, provided by the Administrator (Admin) on 08/04/15. The findings are:	A 043	oxygen in use signs were posted down each hall way where residents rooms are located. In order to ensure compliance with posting "oxygen in use" signs the signs will be fastened with permanent fasteners so that the signs can not be removed. "Oxygen in use" sign will also be mounted to the oxygen rack with permanent fasteners.	

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A 043	Continued From page 55 A. On 08/06/15 at 8:31 am, during observation, 5 oxygen cylinder tanks were observed unsecured in R #7's room. B. On 08/06/15 at 9:15 am, during observation of the hall closet, oxygen cylinder tanks in a rack, 4-lg, 3-med, and 3-sm oxygen cylinder tanks not in a rack (1-lg in a plastic crate lying sideways with a large weight scale lying on top of it). This is a small storage closet which also houses a fire extinguisher and other combustible items. C. On 08/06/15 at 10:40 am, during observation with House Manager (HM) unsecured oxygen cylinder tanks were observed in R #7's room. In addition, multiple secured and unsecured oxygen cylinder tanks of various sizes were observed being stored in 2 unventilated closets. D. On 08/6/15 at 10:40 am, during interview with HM, he confirmed that 1. there were unsecured oxygen cylinder tanks were in R #7's room. 2. that multiple secured and unsecured oxygen cylinder tanks were being stored in the closets and that the closets are not ventilated. HM stated that the oxygen cylinder tanks in the closets were empty tanks from a former resident and should be returned to the oxygen company. When asked how the oxygen cylinder tanks should be secured his response was "In a rack" and confirmed that the oxygen cylinder tanks were not secured properly. HM stated he was not aware that the oxygen cylinder tanks could not be stored in the resident's closet or in any unventilated closet/space E. On 08/11/15 at 10:35 am, during observation,	A 043		

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A 043	Continued From page 56 it was observed that there was no "Oxygen in Use" warning sign posted in the facility or on R 7's room door. F. On 08/11/15 at 12:05 pm, during interview with Administrator and HM, they confirmed that no "Oxygen in Use" warning signs were posted in the facility or on R #7's room door.	A 043		
A 044	7 NMAC 8.2.44 Heating, Air-Conditioning and Ventilation HEATING, AIR-CONDITIONING AND VENTILATION: A. Heating, air-conditioning, piping, boilers and ventilation equipment shall be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities shall 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 shall provide a minimum temperature of seventy (70) degrees fahrenheit, measured at three (3) feet above the floor, in all rooms used by the residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device shall be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances shall be permanently anchored and kept away from flammables such as curtains, bedcovering, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or presents danger from electrical shock. D. Fireplaces and open flame heating shall not be utilized in sleeping rooms.	A 044		

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A 044	Continued From page 57 E. Gas fired water heaters shall not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms. F. The facility shall 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 shall be screened for the control of insects and rodents. Screen doors shall be equipped with self-closing devices. H. The facility shall have a system for maintaining the residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7.8.2.44 NMAC - Rp, 7.8.2.45 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.44 A Based on record review and interview, the facility failed to ensure that the gas furnace was inspected annually. If the furnace is not inspected on an annual basis and either quits working or develops a gas leak then all 15 (R #1-15) resident identified on the resident census, by the Administrator (Admin) on 08/04/15, are at risk of being harmed or becoming ill. The findings are: A. Record review of maintenance records revealed no documentation that the gas furnace had been inspected annually. B. On 08/11/15 at 4:16 pm, during interview with	A 044	In order to correct the violation of not ensuring that the gas furnace was inspected annually we will have the gas furnace inspected by a professional. In order to ensure continued compliance, we will have a designated month for the furnace inspection. We will develop an inspection form that will list all of the equipment/ machinery that requires inspection. The form will list when each piece of equipment	

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A 044	Continued From page 58 Admin and House Manager, they confirmed that the gas furnace had not been inspected annually.	A 044	machinery needs to be inspected. This form will be posted in the office as a reminder of the inspection dates. 10/31/15	
A 045	7 NMAC 8.2.45 Water WATER: Pursuant to the current New Mexico drinking water requirements, 7.6.2.9 NMAC. A. The water supply system shall be constructed, protected, operated and maintained in conformance with applicable local, state and federal laws, ordinances and regulations. B. Where a facility is supplied by its own water system, the system shall meet the sampling and construction requirement of a non-community water system as defined by the current New Mexico drinking water requirements. C. All water that is not piped into the facility directly from a public water supply system shall be from an approved source, disinfected, transported, handled, stored and dispensed in a sanitary manner. Such water shall be prevented from entering potable water systems by appropriate cross connection and backflow prevention devices. D. Hot and cold running water, under pressure shall be provided in all areas where food is prepared and where equipment and utensils are washed, sinks, lavatories, washrooms and laundries. E. The hot water temperature that is accessible to residents shall be maintained at a minimum of ninety-five (95) degrees fahrenheit and a maximum of one hundred ten (110) degrees fahrenheit. Hot water in excess of one hundred ten (110) degrees fahrenheit is permitted in kitchen and laundry areas, provided that residents are supervised in order to prevent injury. [7.8.2.45 NMAC - Rp, 7.8.2.46 NMAC,	A 045	In order to correct the violation of not ensuring that the hot water temperatures that are accessible to residents remain under 110 degrees F, the mixing valve was ajusted so that the water temperatures don't exceed 110 F in shower room and dining room.	

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A 045	Continued From page 59 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that the hot water temperatures that is accessible to residents was maintained at a maximum of 110 degrees Fahrenheit (F). If the water temperature is above 110 degrees F, then all residents (R #1-15), listed on the resident census, provided by the Administrator (Admin) on 08/04/15 are at risk of being burned. The findings are: A. On 08/06/15 at 1:00 pm, during observation the following water temperatures were recorded: 1. Shower room/sink: 120 degrees F. 2. Shower/shower: 120 degrees F. 3. Dining room/Island sink: 119 degrees F. 4. Room #3/bathroom sink: 118 degrees F. B. On 08/11/15 at 10:25 am, during observation the following water temperatures were recorded: 1. Shower room/sink: 125 degrees F. 2. Shower room/shower: 125 degrees F. 3. Dining room/Island sink: 120 degrees F. C. On 08/11/15 at 12:00 noon, during observation with the House Manager (HM) it was observed the shower room sink water temperature was above 120 degrees F. D. On 08/11/15 at 12:00 noon, during interview with HM, he confirmed that the water temperatures in the shower room were above 120 degrees F. HM stated that the temperatures could be adjusted which he would do to make sure all the water temperatures the residents have access to are within the correct range.	A 045	In order to ensure compliance we will develop an inspection form that will list hot water temperature in bedrooms, dining room and shower room. This form will be posted in the office as a reminder of this inspection time 10/31/15	

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A 045	Continued From page 60 E. On 8/11/15 at 12:05 pm, during interview with Admin and HM regarding the dining room island/sink, HM stated that the sink was on the same water line as the kitchen sink which is set at a higher temperature. Since the residents do have access to the island sink, Admin and HM stated they will consult with a plumber for a way to control the hot water temperature.	A 045		
A 060	7 NMAC 8.2.60 Fire Clearence and Inspections FIRE CLEARANCE AND INSPECTIONS: A. Written documentation of a facility's compliance with applicable fire prevention codes shall be obtained from the state fire marshal ' s office or the fire prevention authority with jurisdiction and shall be submitted to the licensing authority prior to the issuance of an initial license. B. The facility shall request an annual fire inspection from the local fire prevention authorities. If the policy of the local fire department does not provide an annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility. [7.8.2.60 NMAC - Rp, 7.8.2.59 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.60 Based on record review and interview the facility failed to ensure that fire inspections were	A 060	In order to correct the violation of not ensuring that the gas furnace was inspected annually we developed an "inspections form". "Fire Inspection" was added to this form. for the month of October. The Fire Marshal will come over to the facility and conduct a Fire Inspection this month. 12/31/15	

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A 060	Continued From page 61 conducted annually by the Fire Marshal's office or a local fire prevention authority. This deficient practice has the potential to affect all 15 (R #1-15) residents listed on the resident census, provided by the Administrator (Admin) on 08/04/15 as well as staff and visitors. If the facility is not conducting annual fire inspections and ensuring the facility is safe in the event of a fire then all 15 residents are at risk for fire and smoke related injuries or death if a fire occurs. The findings are: A. Record of the facility Fire Inspection records revealed that the last Annual Fire and Life-Safety Inspection was completed on 09/26/13. B. On 08/11/15 at 9:25 am, during interview with Admin, she confirmed that the last Annual Fire and Life-Safety Inspection was on 09/26/13.	A 060		
A 061	7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: A. Fire alarm system. Facilities with four (4) or more residents shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction. B. Smoke and heat detection. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining and living room(s) must also be provided with smoke detectors. (1) Detectors shall be powered by the house electrical service and have battery back up. (2) Construction of new facilities or facilities	A 061	In order to correct the violation of not having a lock-out switch on the circuit breaker for the fire alarm system we will have a lock-out switch installed. In order to ensure ongoing compliance,	

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A 061	Continued From page 62 remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room. (3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service. [7.8.2.61 NMAC - Rp, 7.8.2.60 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.61 A Based on interview and observation the facility failed to: 1. be able to locate and identify the circuit breaker with lock-out switch for the fire alarm system.` 2. ensure that all fire alarm strobe lights were flashing in synchronization. 3. ensure the reset key is readily accessible and all staff know where it is located. This deficient practice is likely to cause harm to any of the fifteen (15) residents, identified on the resident census, provide by the Administrator (Admin) on 08/04/15, staff, and visitors if: 1. the circuit breaker for the the fire alarm system does not have a lock-out switch in place and gets turned off then the alarm system may not operate properly in the event of a fire. 2. the strobe lights do not flash in synchronization, then residents may be at risk or having a seizure during an drill or actual evacuation. 3. the fire alarm reset key is not readily available so staff can reset the alarms to ensure they are in working order in case actual fire. The findings	A 061	a label will be placed on the lock-out switch that states, "Do Not Remove." 2) In order to correct the violation of not ensuring that all fire alarm strobe lights are flashing in synchronization, the strobe lights will be adjusted by a professional so that the strobe lights flash in synchronization. In order to ensure compliance, during the fire drills	

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A 061	Continued From page 63 are: Finding related to circuit breaker for the fire alarm system. A. On 08/06/15 at 9:15 am, during observation of the circuit boxes the breaker for the Fire Alarm System could not be identified. B. On 08/06/15 at 10:40 am, during interview with House Manager (HM) he was not able to locate the circuit breaker for the Fire Alarm System in either the North or South hall breaker boxes. HM showed surveyor 3 locked boxes on the outside of the building and stated that he has never opened them since the facility opened, the fire alarm circuit breaker may be in there, there may be a key somewhere. Findings related to Fire Alarm Strobe lights. A. On 08/11/15 at 9:25 am, during observation of the Fire Alarm Strobe lights being tested, it was observed that the lights were not flashing in synchronization. B. On 8/11/15 at 9:27 am, during interview with Admin, she confirmed that the Fire Alarm Strobe lights were not synchronized and that the Fire Alarm System had not been inspected since September 2013, and that no one checks them monthly Findings related to Fire Alarm reset key A. On 08/11/15 at 8:50 am, during observation the Fire Alarm reset key was not found. B. On 08/11/15 at 8:55 am, during interview with staff (S #4 and 9) when asked where the reset	A 061	The strobe lights will be examined to determine that they are flashing in synchronization. 10/31/15 3) In order to correct this violation of not ensuring the reset key is readily accessible and all staff know where it is located. The key was placed in the fire box. In order to ensure compliance when yearly staff training and ~~et~~ orientation are being conducted a demonstration of	

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A 061	Continued From page 64 key was located. S #4 stated that she resets the alarm at the fire alarm panel in the laundry room and does not know where the reset key is. S #9 stated that the reset key is supposed to be in the med closet, but when he looked it was not there. He stated that someone must have put it in their pocket and not put it back. C. On 08/11/15 at 9:05 am, during observation, S #9 searched for the fire alarm reset key and it was eventually located in a kitchen drawer.	A 061	where the key is and how to use it will be added to the Fire Safety Training.	10/31/15
A 062	7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Facilities with nine (9) or more residents shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. [7.8.2.62 NMAC - Rp, 7.8.2.61 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.62 Reference NFPA 13 Section 1-5.1 Maintenance: A sprinkler system installed under this standard shall be properly maintained for efficient service. The owner is responsible for the condition of the sprinkler system and shall use due diligence in keeping the system in good operating condition. Reference NFPA 25, 1-4.2	A 062	In order to correct the violation of not ensuring that the required inspection of the sprinkler system, fire-extinguishing system, and hood will all be inspected this month. In order to ensure continued compliance we	

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A 062	Continued From page 65 The responsibility for properly maintaining a water-based fire protection system shall be that of the owner(s) of the property. By means of periodic inspections, tests, and maintenance, the equipment shall be shown to be in good operating condition, or any defects or impairments shall be revealed. Inspection, testing, and maintenance shall be implemented in accordance with procedures meeting or exceeding those established in this document and in accordance with the manufacturer's instructions. These tasks shall be performed by personnel who have developed competence through training and experience. Reference NFPA 25, 1-4.4 The owner or occupant promptly shall correct or repair deficiencies, damaged parts, or impairments found while performing the inspection, test, and maintenance requirements of this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. Based on observation, record review, and interview, the facility failed to ensure that annual and quarterly inspections of the automatic sprinkler system were being completed. In the event of a fire, the automatic sprinkler system may fail, leading to injury/death by fire to all 15 (R #1-15) residents identified by the Resident Census List provided by the Administrator (Admin) on 08/04/15. The findings are: A. On 08/06/15 at 9:15 am, during observation, the inspection tag on the automatic sprinkler system was dated September 2013 and that there were no signatures indicating that quarterly inspections had been completed.	A 062	will have designated dates for all the inspections. We will develop an inspections form that will list all the required inspections of equipment and machinery. The form will list when each piece of equipment/ machinery need to be inspected. This form will be posted in the office as a reminder of the inspection dates. All inspections/	

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A 062	Continued From page 66 B. Record review of the fire sprinkler inspection records revealed that the last annual inspection of the automatic sprinkler system was conducted 09/26/13. C. Record review of the fire sprinkler inspection records revealed no documentation of quarterly automatic sprinkler inspection being completed. E. On 08/11/15 at 9:25 am, during interview with Admin, she confirmed that the last Annual Fire and Life-Safety Inspection was on 09/26/13. Reference NFPA 96, 1998 Edition 8-2* Inspection. An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons. 8-2.1 All actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire-actuated dampers, shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. In addition to these requirements, the specific inspection requirements of the applicable NFPA standard shall also be followed. Based on observation, record review and interview, the facility failed to ensure the kitchen's range hood suppression system was inspected at least every six months (semi-annual) as required by NFPA 96 (Standard for Ventilation Control and Fire Protection of Commercial Cooking	A 062	inspection forms will be filed in the inspections folder. 10/31/15	

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A 062	Continued From page 67 Operations). Not inspecting the range hood at least every six months could result in the suppression system not activating in the event of fire, which presents a risk of potential harm to all 15 (R #1-15) residents identified on the Resident Census List provided by the Administrator (Admin) on 08/04/15. The findings are: A. On 08/06/15 at 9:15 am, during observation, the inspection tag on the range hood suppression system was dated September 2013. B. Record review of the range hood inspections revealed that the last inspection was performed between 09/26/13 C. On 08/11/15 at 12:05 pm, during interview with Administrator and House Manager they confirmed that the range hood had not been inspected since 09/26/13 and that it was currently not working.	A 062		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet.	A 063	In order to correct the violation of not inspecting the fire extinguishers monthly for charge and condition the fire extinguishers were checked and each	

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A 063	Continued From page 68 B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 B Based on observation and interview the facility failed to ensure that the fire extinguishers were checked on a monthly basis to see if they need recharging or need repair. If the fire extinguishers are not properly charged or need repair at all times, then all 15 (R #1-15) residents listed on the resident census, provided by the Administrator (Admin) on 08/04/15 are at risk of harm if a fire occurs: The findings are: A. On 08/06/15 at 9:15 am, during observation, there were no staff signatures indicating that monthly inspections had been completed on any of the facility fire extinguishers. B. On 08/6/15 at 10:40 am, during interview with the House Manager (HM), he confirmed that the tags on the fire extinguishers had not been signed by staff indicating that monthly inspections had occurred. HM stated that he was not aware they had to be signed each month. C. Record review of the monthly fire drill forms where staff document monthly fire extinguisher inspections revealed no documentation that fire extinguishers inspections had occurred in the months of October, November, and December	A 063	fire extinguisher tag was marked(dated) In order to ensure continued compliance the statement "Check all fire extinguishers for proper charge and good condition. Initial and date all extinguishers. Document any comments or concerns." will be added to our fire drill form. 10/21/15	

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A 063	Continued From page 69 2014 and July 2015.	A 063		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 A, B(1) Based on record review and interview, the facility failed to ensure that there were documented fire drills conducted monthly and that at least 1 documented fire drill was conducted each 8 hours (day, evening, and night) per quarter. This deficient practice could result widespread harm to all 15 (R #1-15) residents, identified on the resident census, provided by the Administrator	A 065	In order to correct the violation of skipping fire drills we will conduct fire drills every month and at least 1 documented fire drill will be conducted each 8 hours (day, evening and night) per quarter. To ensure continued compliance Fire Drills will be added to our	

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A 065	Continued From page 70 (Admin) if staff is not being adequately prepared to exercise their duties in accordance with the facility's fire plan in the event of a fire. The findings are: A: Record review of monthly fire drill records dated August 2014 thru July 2015 revealed no documentation that monthly fire drills were completed for the months of October 2014, November 2014, or December 2014. B: Record review of the monthly fire drill records dated August 2014 thru July 2015 revealed no documentation the fire drills had been completed during the evening or night hours. C: On 08/06/15 at 3:15 pm, during interview with Admin and House Manager (HM), they confirmed that the fire drills have not been done on each 8 hr shift each quarter and they confirmed that there was no documentation that fire drills were done in October, November, and December of 2014.	A 065	inservices from. The form will state that 1 fire drill must be conducted each 8 hours (day, evening, and night) per quarter. 10/31/15	
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening	A 070		

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A 070	Continued From page 71 Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: .1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. Based on record review, interview, and observation the facility failed to ensure the safety and welfare for all residents (R #1-15), identified	A 070	This violation - violation/deficiency A070 is listed twice. This violation/deficiency is also listed on page 3 under deficiency A016	

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A 070	Continued From page 72 on the resident census, by the Administrator (Admin) on 08/04/15 by not obtaining pre-hire clearances form the Employee Abuse Registry (EAR) and not submitting applications for new hires to the Criminal History Screening Program (CCHSP) within 20 days from employment. This deficient practice is likely to result in the facility hiring a direct care staff person who has a previous history of abusing, neglecting, or exploiting individuals under their care or a convicted felon. The findings are: Findings related to the EAR/CCHSP: A. Record review of staff files revealed that staff (S #3) had a hire date of 12/05/06, however, her EAR clearance summary was dated 07/18/07, and her CCHSP clearance letter was dated 09/20/07. B. Record review of staff files revealed that S #4 had a hire date of 11/22/06 (per Admin), however, her EAR clearance summary was dated 02/05/08, and her CCHSP clearance letter was dated 01/22/07. C. Record review of staff files revealed that S #5 had a hire date of 05/14/15, however, her EAR and CCHSP application was not submitted by the facility until 08/04/15 after the administrator was informed by the Licensing Authority and directed to contact CCHSP for direction. D. Record review of staff files revealed that S #7 had a hire date of 07/02/15, however, her EAR and new CCHSP application (previous clearance for different employer was dated 04/25/15 was not submitted by the facility until 08/04/15 after the administrator was informed by the Licensing Authority and directed to contact CCHSP for direction.	A 070		

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A 070	Continued From page 73 E. Record review of staff files revealed that S #8 had a hire date of 07/19/15, however, EAR was not submitted by the facility until 08/04/15 after the Admin was informed by the Licensing Authority and directed to contact CCHSP for direction. Her CCHSP Authorization to Release Information was not signed until 08/06/15. F. Record review of staff files revealed that S #9 had a hire date of 07/15/09, however, his EAR summary has a date of 05/15/11, and his CCHSP clearance letter has a date of 03/24/11. G. On 08/07/15 at 12:31 pm, during interview with Admin, she confirmed that the EAR and CCHSP had not been completed as required by regulation.	A 070		