

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <i>1st Original</i>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/18/2009	
NAME OF PROVIDER OR SUPPLIER SIERRA SPRINGS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 503 LOS LENTES ROAD NE LOS LUNAS, NM 87031		
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A22	<p>7 NMAC 8.2.22 Resident Records</p> <p>7.8.2.22 RESIDENT RECORDS: A. RESIDENT RECORDS, CONTENTS: A record for each resident shall be maintained with specific information required. Entries in each resident's record shall be legible, dated, and authenticated by the signature of the person making the entry. Resident records must include:</p> <p>(1) Admission records as set out in Section 7.8.2.21 NMAC:</p> <p>(2) Within five (5) days of admission: (a) An executed admission agreement. (b) A completed resident assessment form. (c) Any available, admission physical examination report by a licensed health care professional, which may include all discharge information from another facility. When admission follows within thirty (30) days discharge from an acute care hospital, the hospital history and physical report, and the hospital discharge summary may serve as an admission physical. (d) Names, addresses, relationship, and phone numbers of family members, and where appropriate, guardians, agents, and any surrogate decision makers. (3) Within thirty (30) days of admission: (a) A admission physical examination report by a licensed health care professional if an examination report was not available within five (5) days of admission. (b) Resident's name, age, recent photograph, social security number, marital status, date of birth, sex, address prior to admission, religion (optional), personal physician, dentist, social history and designated representative or other emergency contact person, language spoken and understood, legal documentation relevant to commitment and/or guardianship status, present medications, and</p>	A22 <i>Scanned 4-8-09 M</i>	<p><i>This violation was/will be corrected by: The medication, Larazepam, was listed in the MAR according to the specifications of the Health Facility Licensing Bureau. We will also change the format of the MAR to include a chart on the reverse side of each MAR sheet that will include a place to write down notes to explain why a medication was not given. Instructions on how the medication assistant is to chart a missed medication.</i></p> <p><i>We will identify other residents having the potential to be affected by the deficiency by: A monthly medication audit will be performed. On the audit sheet will be the questions: Was there any circled initials without notes on the reverse side of each Mar? Also, were there any scheduled dose boxes left blank (without initials)? The audit form will also address many other types of issues regarding</i></p>	

Division of Health Improvement

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

TITLE

Administrator

(X6) DATE

4/7/09

STATE FORM

RH6811

If continuation sheet 1 of 15



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A22	Continued From page 1 diet required. (c) Any amendments to the admission agreement. (d) The current completed resident assessment form. (e) A completed and current individual service plan. (f) Entries by direct care staff, appropriate health care professionals, or others authorized to care for the resident. Entries shall be dated and signed by the person making the entry and shall include significant information related to the individual service plan. (g) Entries providing a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention, and entries reflecting appropriate follow-up. The maintenance of such written record in the resident record may be by copy of an incident/accident report, if the original incident/accident report is maintained elsewhere by the facility. (h) A medication record: Medications administered by licensed personnel and/or staff assisting with medications to include: listing all currently ordered medications by name, dosage, administration times; documenting by medication name, dosage, date, and time, each medication administered, with the initials of the individual who administered or assisted with the medication; documentation of errors, omissions, and side-effects of medications; and written consent by resident or guardian for staff to assisting with medications. (i) Date, time and progress note of health services provided by any contract agency. (j) Unless included in the admission	A22	<i>medication distribution. We will monitor the corrective action by adding the following statement to the pharmacist's quarterly audit sheet: Was there a monthly audit performed by the facility by evidence of a completed audit sheet for each month this past quarter?</i>	4/17/09

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A22	<p>Continued From page 2</p> <p>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.</p> <p>(k) Transfer forms completed, signed, and provided to accepting facility when resident is transferring to a hospital or another health care facility.</p> <p>(l) Documentation of disposition of the resident's personal effects and money or valuables deposited with the adult residential care facility, upon death or transfer.</p> <p>B. RESIDENT RECORDS, MAINTENANCE:</p> <p>(1) Resident records shall be maintained and stored in an organized, accessible and permanent manner.</p> <p>(2) The facility shall establish a policy for maintaining, and confidentiality of resident records, including the authorized release of resident records.</p> <p>(3) Resident records must be maintained by the facility against loss, destruction, and unauthorized use for a period of not less than three (3) years from the date of discharge.</p> <p>(4) There must be a policy and procedure in place for record retention in the event of facility closure. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 7.8.2.22 NMAC - Rn 7 NMAC 8.2.22, 8-31-00]</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22697 Refer to 7.8.2.22 A. (3) (h) . . . listing all currently ordered medications . . . documentation of errors, omissions . . .</p> <p>Based on record review and interview the facility</p>	A22		

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A22	<p>Continued From page 3</p> <p>failed to list all currently ordered medications, document errors, and document omissions on the Medication Administration Record (MAR) for 3 of 4 residents (R1, R5, & R6). The findings are:</p> <p>A. Record review on 3/18/09 of the March, 2009 MAR for resident R6 revealed no listing for the medication Lorazepam. Physician prescription orders dated 2/26/09 read, "Lorazepam 1mg - Take 1 tablet by mouth at bedtime.</p> <p>B. In an interview with the administrator on 3/18/09 at 8:15 a m, the administrator acknowledged the Lorazepam was not listed on the MAR for resident R6.</p> <p>C. Record review on 3/18/09 of the March, 2009 MAR for resident R1 revealed Physician's order for Metformin 500 mg - Take 2 tablets in the morning and 1 tablet at 3 p m. The scheduled doses for 8:30 a m on 3/7/09 and 3/8/09 were circled as not administered and there were no notes to explain why they were not administered.</p> <p>D. Record review on 3/18/09 of the March, 2009 MAR for resident R5 revealed Physician's order for Citrucel - Take 1 tablespoon twice a day. On 3/17/09 the scheduled dose for 8:30 am was blank and the dose scheduled for 7:30 p m was circled as not administered. There were no notes to explain the omission or why it was not administered.</p> <p>E. Record review on 3/18/09 of the March, 2009 MAR for resident R6 revealed Physician's order for Hydrocodone/APAP 5/325 mg - Take 1 tablet by mouth every 8 hours. The scheduled dose for 11:00 p m for 3/1, 3/2, 3/8, 3/9, and 3/16/09 were blank with no notes to explain the omissions.</p>	A22		

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A22	Continued From page 4 F. In an interview with the administrator on 3/18/09 at 8:15 a m, the administrator acknowledged the above listed omissions and entries signifying medications not given. The administrator further acknowledged there were no notes to explain the omissions and entries signifying medications not given.	A22		
A26	7 NMAC 8.2.26 Resident Assessment 7.8.2.26 RESIDENT ASSESSMENT: A. A resident assessment to determine level of function and if the client's needs can be met by the facility. The initial assessment must be completed within five (5) days of admission and reviewed every six (6) months as part of the individual service plan. B. The resident assessment must establish a baseline in the resident's functional status and thereafter, identify resident changes through periodic reassessments. C. The resident assessment must be documented on a state approved resident assessment form and at a minimum include the following: <ul style="list-style-type: none"> (1) Cognitive patterns. (2) Communication/hearing patterns. (3) Vision patterns. (4) Physical functioning and structural problems. (5) Continence. (6) Psycho social well-being. (7) Mood and behavior patterns. (8) Activity pursuit patterns. (9) Disease diagnoses. (10) Health conditions. (11) Oral/nutritional status. (12) Oral/dental status. (13) Skin conditions. (14) Medication use. 	A26	<p><i>This violation will be corrected by: We will begin using a less confusing assessment form for all of our assessments. we will redo all of our assessments, and ISPs for our current residents, and use the new assessment form for all new admits.</i></p> <p><i>We will identify other residents having the potential to be affected by the deficiency by: Reassessing all of our current residents and using the new assessment form, and by redoing all of our ISPs after we complete the assessments.</i></p>	

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A26	<p>Continued From page 5</p> <p>(15) Special treatment and procedures. D. The resident admission assessment, the physical exam report, and the observation and evaluation of staff with regards to the needs will be used to develop the individual service plan, if needed. If the resident assessment does not indicate a need for an individual service plan, then an individual service plan is not required. However, an individual service plan must be prepared for residents requiring nursing services. [4-7-97; 7.8.2.26 NMAC - Rn, 7 NMAC 8.2.26, 8-31-00]</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22697 Refer to 7.8.2.26</p> <p>Based on record review and interview the facility failed to document a health condition and contradicted another health condition for 1 on 4 residents (R2). The findings are:</p> <p>A. Record review on 3/17/09 revealed an assessment for resident R2 that revealed the following: 1. Under section labeled, "CONTINENCE," it was documented as resident having full bowel and bladder control, 2. Under the section of "Health Conditions," it was documented resident was incontinent. 3. The Individual Service Plan states the resident is Oxygen dependant, and 4. The assessment had no documentation of Oxygen dependency.</p> <p>B. In an interview with the administrator on 3/17/09 at 2:07 p m, the administrator acknowledged the assessment for resident R2 had contradictory information and did not document the resident's oxygen dependency.</p>	A26	<p><i>We will monitor our corrective action by:</i> <i>Requiring the administrator to personally review every resident file to verify that each resident has a new assessment using the new assessment form recommended by the surveyor, and that each resident has a revised ISP. When a file has been reviewed, the administrator will mark the file as COMPLETED to signify that she has reviewed the file.</i></p>	4/17/09

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A27	<p>7 NMAC 8.2.27 Individual Services Plan</p> <p>7.8.2.27 INDIVIDUAL SERVICE PLAN: A. An individual service plan, if prompted by the resident assessment, shall be developed and implemented within fourteen (14) days of admission, and must address those areas of need as identified in the resident assessment. The individual service plan must be reviewed by a licensed nurse at least every six (6) months, and revised as needed at the time of each assessment and consistently implemented in response to the resident's needs. B. The individual service plan must include the following: (1) Description of identified needs as noted in the resident assessment. (2) Written description of what services will be provided. (3) Who will provide the services. (4) When or how often the services will be provided. (5) How the services will be provided. (6) Where the services will be provided. (7) Goal and outcome of the service. (8) Documentation of the facility's determination that it is able to meet the needs of the resident. [7-11-86, 1-11-90, 4-7-97; 7.8.2.27 NMAC - Rn, 7 NMAC.8.2.27, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 22697 Refer to 7.8.2.27 B. (1) Description of identified need ...</p> <p>Based on record review and interview the facility failed to have descriptions of identified needs on the Individual Service Plan (ISP) for 1 of 4 residents (R4). The findings are:</p>	A27	<p><i>This violation will be corrected by: Adding a section to our ISP form that will list Goal and outcome of service for each service rendered.</i></p> <p><i>We will identify the residents having the potential to be affected by the deficiency by: Reducing all of our current resident's ISPs on the revised ISP form. We will use the new form for all new admits as well.</i></p> <p><i>We will monitor the corrective action by: Requiring the administrator to review every revised</i></p>	

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A27	Continued From page 7 A. Record review on 3/17/09 revealed a detailed identified need of cognitive assistance and an identified need of mobility assistance on the assessment for resident R4 and there was no description on the ISP to address these identified needs. B. In an interview with the administrator on 3/17/09 at 2:12 p m, the administrator acknowledged the identified need of cognitive assistance and the identified need of mobility assistance were not described or addressed on the ISP. Refer to 7.8.2.27 B. (7) Goal and outcome of service. Based on record review and interview the facility failed to include goals and outcomes on the Individual Service Plans (ISP's) for 4 of 4 residents (R1, R2, R3, & R4). The findings are: A. Record review on 3/17/09 of the ISP's for residents R1, R2, R3, and R4, revealed no goals or outcomes for any of the needs identified on the ISP's. B. In an interview with the administrator on 3/17/09 at 2:20 p m, the administrator acknowledged there were no goals or outcomes for any of the identified needs on the ISP's for residents R1, R2, R3, and R4.	A27	<i>resident ISP, and verify that the new form was used by noting on the ISP - Revised ISP completed, for all of our residents. We will no longer use the ISP format without Goals & Outcomes listed.</i>	4/17/09
A35	7 NMAC 8.2.35 Custodial Drug Permit 7.8.2.35 CUSTODIAL DRUG PERMIT: Any facility licensed pursuant to these regulations who supervises the administration, self-administration, or safeguards medications for residents, must	A35		

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A35	<p>Continued From page 8</p> <p>have a current custodial drug permit issued by the State Board of Pharmacy. EXCEPTION: Adult residential care facilities with one (1) resident are not required to have a custodial drug permit.</p> <p>A. PROCUREMENT, LABELING, AND STORAGE: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as required by the individual or specified by the individual's health care plan. The facility shall procure, label, and store medications for residents in a manner which shall be in compliance with state and federal laws.</p> <p>(1) All medications, including non-prescription drugs, will be stored in a locked compartment or in a locked room, as approved by the Board of Pharmacy, and the key will be in the care of the director or designee.</p> <p>(2) Internal medication must be kept separate from external medications. Drugs to be taken by mouth will be separated from all other dosage forms.</p> <p>(3) A separate locked compartment will be available in the refrigerator for those items labeled "keep in refrigerator." The refrigerator temperature will be kept between thirty-five (35) and forty-five (45) degrees Fahrenheit. A thermometer is required to be kept in the refrigerator.</p> <p>(4) All medications, including non-prescription medications, must be stored in separate compartments for each resident and all medications will be labeled with the residents' names.</p> <p>(5) A resident may be permitted to keep his/her own medication in a secure place in his/her room for self-administration if the physician's report has deemed it appropriate that the resident do so.</p>	A35	<p><i>This violation will be corrected corrected by:</i></p> <p><i>The contract with our pharmacist will be revised. It will state he is required to make quarterly reviews of our medication closet; Furthermore, we will add to the pharmacist's audit form that the narcotic count forms are also to be audited for each narcotic in our closet.</i></p> <p><i>We will identify other residents having the potential to be affected by the deficiency by:</i></p> <p><i>Setting the quarterly reviews for designated months. The designated months for quarterly reviews will be: January, April, July, and October. The designated months</i></p>	

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A35	Continued From page 9 (6) The facility may not require the resident to purchase prescriptions from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes must comply with National Fire Protection Association (NFPA) 99. B. CONSULTING PHARMACIST: The facility shall maintain records demonstrating the consulting pharmacist provides the following: (1) Reviews the medication regimen as needed, but at least quarterly (every three (3) months), to determine that all medications and records are accurate and current. All irregularities must be reported to the Director of the facility and these irregularities must be acted upon. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation is provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. [7-1-64, 9-15-70, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.35 NMAC - Rn, 7 NMAC 8.2.35, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 22697 Refer 7.8.2.35 B. (1) Reviews the medication regimen . . . at least quarterly (every 3 months). Based on record review and interview the facility failed to have quarterly reviews by the consulting Pharmacist. The findings are:	A35	<i>That the pharmacist's audits are due will be listed on the contract agreement between the pharmacist and the facility. How we will monitor the corrective action: The pharmacist will receive a reminder call from the administrator during the first week of each month that is designated for a review. The administrator will document the call in the Pharmacist Binder.</i>	4/17/09

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A35	Continued From page 10 A. Record review on 3/18/09 revealed the Pharmacist last reviewed the medication regimen on 7/16/08 and the previous review was dated 1/26/08. B. In an interview with the administrator on 3/17/09 at 2:30 p m, the administrator acknowledged the Pharmacist's reviews had not been done quarterly as required. Refer to 7.8.2.35 B. (2) A system of records of receipt and disposition of all drugs . . . Based on record review and interview the facility failed to maintain records of disposition of narcotics for 1 resident (R6). The findings are: A. Record review on 3/18/09 revealed 3 narcotic shift change count forms for resident R6 with several blanks where entries should be at shift change. The Narcotics not regularly counted were Larazapam, Hydrocodone, and Zolpidem. B. In an interview with the administrator on 3/18/09 at 8:20 a m, the administrator acknowledged the 3 narcotic shift change forms for resident R6 had several blanks where there should have been entries for count at shift change.	A35		
A66	7 NMAC 8.2.66 Related Regulations & Codes 7.8.2.66 RELATED REGULATIONS AND CODES: Adult residential care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows: A. Health Facility Licensure Fees and	A66		

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A66	<p>Continued From page 11</p> <p>Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96).</p> <p>B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96).</p> <p>C. Adjudicatory Hearings, New Mexico Department of Health, 7 NMAC 1.2 (2-1-96). [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.66 NMAC - Rn, 7 NMAC 8.2.66, 8-31-00]</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22697</p> <p>Refer to 7.8.2.66 RELATED REGULATIONS AND CODES:</p> <p>TITLE 7 HEALTH CHAPTER 1 HEALTH GENERAL PROVISIONS PART 12 EMPLOYEE ABUSE REGISTRY</p> <p>7.1.12.8 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.</p> <p>A. Provider requirement to inquire of registry. A</p>	A66	<p><i>This violation will be corrected by: Inquiring of the Abuse Registry (COR) for all of our employees. New hires will receive a COR review before, or on the first day of hire. Documentation of each inquiry will be noted in each employee file. We will also ^{and} fingerprint, fees, and the required information to CCHS within 30 days of hire for all employees.</i></p> <p><i>We will identify other residents having the potential to be affected by the deficiency by: During the interview of each potential employee the potential employee will be inquired of using the COR. Our application</i></p>	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/18/2009
NAME OF PROVIDER OR SUPPLIER SIERRA SPRINGS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 503 LOS LENTES ROAD NE LOS LUNAS, NM 87031		
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A66	<p>Continued From page 12</p> <p>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.</p> <p>Based on record review and interview the facility failed to make inquiry to the Employee Abuse Registry (COR) before or on the first day of employment for 2 of 4 employees (S20 & S21). The findings are:</p> <p>A. Record review on 3/18/09 revealed staff S20 was hired on 2/11/09 and there was no documentation from COR.</p> <p>B. Record review on 3/18/09 revealed staff S21 was hired on 2/28/09 and there was no documentation from COR.</p> <p>C. In an interview with the administrator on 3/18/09 at 9:50 a m, the administrator acknowledged there was no documentation from COR for staff S20 and S21.</p> <p>TITLE 7 HEALTH CHAPTER 1 HEALTH GENERAL PROVISIONS PART 9 CAREGIVERS CRIMINAL HISTORY SCREENING REQUIREMENTS</p> <p>7.1.9.7 DEFINITIONS: For purposes of this rule, the following definitions shall apply:</p> <p>B. "applicant" means a person who applies, and is offered employment or contractual service with a care provider to provide services as a caregiver or hospital caregiver whether as an employee or contractor.</p>	A66	<p><i>for employment will be modified. The application will have an additional question that asks: Did you inquire of the COR regarding this applicant? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</i></p> <p><i>All new employee orientations will include finger printing for the CCHS. The orientation check list will include Criminal History Screening.</i></p> <p><i>We will monitor the corrective action by: Reviewing all employ files on the 15th of every month. If the file contains all requirements including CCHS documentation, the file will be marked complete.</i></p> <p style="text-align: right;"><i>4/17/09</i></p>	

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A66	Continued From page 13 D. " caregiver " means any person whose employment or contractual service with a care provider includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that provider. K. " hospital caregiver " means any person whose employment or contractual service with a care provider includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that care provider in an inpatient setting who is not a licensed New Mexico health care professional practicing within the scope of a profession ' s license. 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. Based on record review and interview the facility failed to send fees and pertinent information to the Criminal History Screening program within 20 days of date of hire for 1 of 3 employees (S20). The findings are: A. Record review on 3/18/09 revealed staff S20	A66		

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A66	Continued From page 14 was hired on 2/11/09 and there was no documentation that fees and all pertinent information had been sent to CCHS. C. In an interview with the administrator on 3/18/09 at 9:50 a m, the administrator acknowledged staff S20 had not been fingerprinted and fees and pertinent information had not been sent to CCHS.	A66		