

*1st Set*

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <b>RECITED TAGS</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>5720</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>01/22/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ACANTILADO VISTA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>920 RIVERVIEW DRIVE SE RIO RANCHO, NM 87124</b>
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{A26}	<p>7 NMAC 8.2.26 Resident Assessment</p> <p>7.8.2.26 RESIDENT ASSESSMENT:</p> <p>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.</p> <p>B. The resident assessment must establish a baseline in the resident's functional status and thereafter, identify resident changes through periodic reassessments.</p> <p>C. The resident assessment must be documented on a state approved resident assessment form and at a minimum include the following:</p> <ol style="list-style-type: none"> <li>(1) Cognitive patterns.</li> <li>(2) Communication/hearing patterns.</li> <li>(3) Vision patterns.</li> <li>(4) Physical functioning and structural problems.</li> <li>(5) Continence.</li> <li>(6) Psycho social well-being.</li> <li>(7) Mood and behavior patterns.</li> <li>(8) Activity pursuit patterns.</li> <li>(9) Disease diagnoses.</li> <li>(10) Health conditions.</li> <li>(11) Oral/nutritional status.</li> <li>(12) Oral/dental status.</li> <li>(13) Skin conditions.</li> <li>(14) Medication use.</li> <li>(15) Special treatment and procedures.</li> </ol> <p>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</p>	{A26}		

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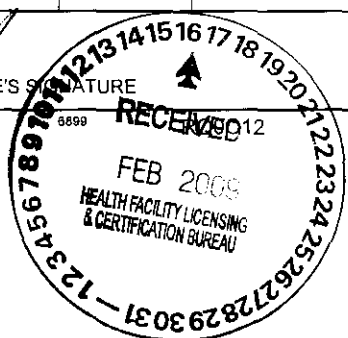
Division of Health Improvement

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

STATE FORM

TITLE *General Manager*

(X6) DATE  
*2/10/09*



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{A26}	Continued From page 1  prepared for residents requiring nursing services. [4-7-97; 7.8.2.26 NMAC - Rn, 7 NMAC 8.2.26, 8-31-00] This REQUIREMENT is not met as evidenced by: This is a repeat deficiency from the November 18, 2008 survey. This deficiency was not corrected as stated in the plan of correction.  Refer to 7.8.2.26 C - Resident Assessment  Based on record review and interview the facility failed to ensure that resident assessments included all minimum requirements as listed in the New Mexico regulations or Adult Residential Care Facilities for 4 of 7 sampled residents.  The findings are:  A. On 1/28/09 during review of resident files it was noted that the resident assessment used by the facility did not include the following elements; (7) Mood and Behavioral Patterns, (9) Disease Diagnoses, (10) Health Conditions, and (13) Skin Conditions for Resident #3, #4, #5, and #6.  B. On 1/28/09 during an interview with the administrator, he acknowledged the stated elements were not found within the assessment.	{A26}	7.8.2.26  Corporate Health and Wellness Director and Community Health and Wellness Manger revised resident assessment form to include; mood and behavioral patterns, disease diagnoses, health conditions and skin conditions  All current residents may have been affected by deficiency. Health and Wellness Manager re-evaluated and added an addendum to include; mood and behavioral patterns, disease diagnosis, health conditions and skin conditions.  Revised Leisure Care form attached and will be used on all assessments to maintain state standards.  All AL residents will be re assessed using the new form by February 28 <sup>th</sup> 2009	
{A27}	7 NMAC 8.2.27 Individual Services Plan  7.8.2.27 INDIVIDUAL SERVICE PLAN: A. An individual service plan, if prompted by the resident assessment, shall be developed and implemented within fourteen (14) days of admission, and must address those areas of need as identified in the resident assessment. The individual service plan must be reviewed by a licensed nurse at least every six (6) months, and	{A27}		

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{A27}	Continued From page 2  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: This is a repeat deficiency from the November 18, 2008 survey. This deficiency was not corrected as stated in the plan of correction.  Refer to 7.8.2.27 B - INDIVIDUAL SERVICE PLAN/Care Plan  Based on record review and interview the facility failed to ensure that resident care plans included all minimum requirements as listed in the New Mexico regulations or Adult Residential Care Facilities 7 of 7 sampled residents.  The findings are:  A. On 1/28/09 during review of resident files it was noted that the resident care plan used by the facility did not include the following elements; (4)	{A27}	7.8.2.27 Corporate Health and Wellness Director and Community Health and Wellness Manager revised the Resident Care Plan to include: when, how often services are provided, goal and outcome of services provided and documentation of facility's determination that we are able to meet the needs of the resident.  All residents that have been previously evaluated are affected. Each file will be redone with a new care plane covering: when and how often services are provided, goal and outcome of services provided, and documentation of facility's determination that we are able to meet the needs of the residents.  Health and Wellness Manager will monitor that this is being accomplished by monthly file audits.  New Care Plans based on revised Assessments will be done for all AL residents by February 28 <sup>th</sup> , 2009	

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{A27}	Continued From page 3  When or how often 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.  B. On 1/28/09 during an interview with the administrator, he acknowledged the stated elements were not consistently found within the assessment.	{A27}	7.8.2.27 Implementation of Service Plans.  Training of all care staff in how to read care plans will be conducted monthly. Staff will be instructed to no longer highlight parts of the care plan to eliminate confusion .	
	This is a new deficiency discovered during the revisit on 1-28-08  Refer to 7.8.2.27 A -Implementation of Service Plans  Based on record review and interview the facility failed to ensure that resident care plans were being implemented for 3 of 3 sampled residents.  A. On 1/28/09 during review of resident files it was noted that the resident care plans were not being implemented in random areas of care. Staff initials indicate a specific service has been delivered to the residents as per individual care plan. According to the care plans for Resident #1, #2 and #3, some areas of service are not being implemented, evident by the absence of staff initials.  B. On 1/28/09 during interview with the administrator, he acknowledge all areas of the care plans are not being implemented.  C. On 1/28/09 during interview with Staff #1, she stated that she does not know how to read the		Health and Wellness director will audit care plans monthly to ensure that care is being given per the written plan.  All residents were affected by the deficiency as they may not have been receiving the care outlined in the plan.  Care Plans will be rewritten in plain language so any staff can determine the required action. Staff will have monthly training on how to read and complete care plans properly. All care plans will be correct and utilized properly no later than February 28 <sup>th</sup> , 2009. A monthly audit log will be kept in the HW office for inspection and it will be audited by the GM for correctness.	

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{A27}	Continued From page 4  care plan, staff do not read the care plans, and that they are only trained to initial the highlighted areas of the care plan.	{A27}			