STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2049	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 09/08/2011
NAME OF PROVIDER OR SUPPLIER MILLIE'S CENTER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH HUDSON STREET SILVER CITY, NM 88061		

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A 000	Initial Comments	A 000		
	The following survey is the result of a complaint investigation conducted for intake NM00027856 on 09/08/11 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The complaint was unsubstantiated. Deficiencies were cited.			
A 020	7 NMAC 8.2.20 Admissions and Discharge	A 020		
	ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and			

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A 020	Continued From page 1	A 020		

(12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances:
(a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination;
(b) the resident has failed to pay for a stay at the facility as defined in the admission agreement;
(c) the facility ceases to operate or is no longer able to provide services to the resident;
(d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility;
(e) termination without prior notice is permitted in emergency situations for the following reasons:
(i) the transfer or discharge is necessary for the resident's safety and welfare;
(ii) the resident's needs cannot safely be met in the facility; or
(iii) the safety and health of other residents and staff in the facility are endangered;
(13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and
(14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents.
B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following:

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A 020	Continued From page 2	A 020		

(1) ventilator dependency;
(2) pressure sores and decubitus ulcers (stage III or IV);
(3) intravenous therapy or injections;
(4) any condition requiring either physical or chemical restraints;
(5) nasogastric tubes;
(6) tracheostomy care;
(7) residents that present an imminent physical threat or danger to self or others;
(8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP;
(9) residents with a diagnosis that requires isolation techniques;
(10) residents that require the use of a Hoyer lift; and
(11) ostomy (unless resident is able to provide self care).
C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements.
(1) Convene a team, comprised of:
(a) the facility administrator and a facility health care professional if desired;
(b) the resident or resident ' s surrogate decision maker; and
(c) the hospice or home health clinician.
(2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall:

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A 020	Continued From page 3	A 020		

(a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met;
(b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES);
(c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and
(d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility.
(3) The team recommendation shall be maintained on site in the resident ' s file.
(4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident.
D. Coordination of care.
(1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers.
(2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider.
[7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced

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A 020	Continued From page 4 by: This is a repeat deficiency from survey dated 04/15/09. Based on record review and interview the facility failed to have evidence of a team meeting to jointly decide the appropriateness of admission/retention of 2 of 2 (#1 &#2) residents requiring a greater degree of care than the facility would normally provide or is permitted to provide and were receiving services from an outside agency. This deficient practice has the potential for inappropriate care of the residents due to the facility not having team recommendations and identification of the specific needs of the residents. The findings are: A. Review of resident records for residents #1 and #2 revealed no evidence of a team meeting. The record of visit slips from skilled agencies revealed resident #1 was receiving skilled services from a Home Health agency and resident #2 was receiving skilled services from a Hospice agency. B. In an interview with the office manager on 09/07/11 at 3:30 pm, the office manager acknowledged there was no documentation of a team meeting for residents #1 or #2 and did not know if there were meetings for the two residents.	A 020	A-0020-7NMAC 8.2.20 Admissions and Discharge We have purchased a scanner and are now saving all resident documents electronically. Documents from current residents are being scanned and saved in the manner of our electronic organization (outline enclosed). New resident information will be input within a week of their residency at MALC. Our intention is to never lose track of resident documentation again! **Completion Date:** No later than July 17, 2011 for current residents.	
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	A 021		

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A 021	Continued From page 5	A 021		

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;
(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

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A 021	Continued From page 6 (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 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.	A 021		

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A 021	Continued From page 7 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: Based on record review and interview the facility failed to have an admissions physical examination report on file for 1 of 2 resident charts reviewed (#1). This deficient practice has the potential for inappropriate care of the residents due to the facility not having a diagnosis of the resident's physical and mental condition. The findings are: A. Review of records revealed resident #1 was admitted on 10/06/04 and no physical examination report was on file for resident #1. B. In an interview with the office manager on 09/07/11 at 3:30 pm, the office manager looked through the chart for resident #1 and	A 021	A-0021-7NMAC 8.2.21 Resident Records We have included the following language in our Resident Contract and will follow through if Resident or Resident's Family does not provide the necessary information. "If a new resident's history and physical is not provided to MALC staff in less than 10 days upon residency at MALC, then MALC staff will terminate the contract without prior notice." **Completion Date:** MALC's contract has been revised. We will use it with all upcoming new residents and will enforce our words.	

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A 021	Continued From page 8 acknowledged there was no physical examination report from a physician, nurse practitioner, or physician's assistant.	A 021		
A 023	7 NMAC 8.2.23 Pets PETS: Pets are permitted in a licensed facility, in accordance with the facility's rules. A. Prohibited areas. Animals are not permitted in food processing, preparation, storage, display and serving areas, or in equipment or utensil washing areas. Guide dogs for the blind and deaf and service animals for the handicapped shall be permitted in dining areas pursuant to Subsection K of 7.6.2.9 NMAC. B. Vaccination. Pets shall be vaccinated in accordance with all state and local requirements and records of such vaccination shall be kept on file in the facility. [7.8.2.23 NMAC - Rp, 7.8.2.24 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure pets were not allowed in the food preparation and serving areas. This has the potential of contamination of food and food serving area which could affect the health and safety of all eleven residents. The findings are: A. During a tour of the facility on 09/07/11 at 12:05 pm, a medium size tan dog with no collar or tags was observed roaming through the dining room and kitchen of the facility. B. In an interview with the administrator on 09/07/11 at 3:00 pm, the administrator acknowledged she did not have any	A 023	A-0023-7NMAC 8.2.23 Pets We have made a sign and it will be installed this week at the entryway to the dining room and kitchen that states "Notice: No animals allowed in dining room or kitchen." All staff and residents have been advised of the importance of this rule. **Completion Date:** No later than June 29, 2012.	

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A 023	Continued From page 9 documentation on the dog for vaccinations.	A 023		
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 (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;	A 025		

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A 025	Continued From page 10 (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 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, 7.8.2.26 NMAC, 01/15/2010]	A 025		
	This REQUIREMENT is not met as evidenced by: This is a repeat deficiency from survey dated 04/15/09. Based on record review and interview the facility failed to have the resident evaluations reviewed and updated every 6 months for 2 of 2 (#1 & #2) resident's charts reviewed. This deficient practice has the potential for inappropriate care of the residents due to changes in needs not being addressed. The findings are: A. Review of records revealed the evaluation for resident #1 was reviewed on 11/14/09, 07/24/10 and 08/12/11. This was 8 months and 13 months respectively between evaluations.		A-0025-7NMAC 8.2.25 Resident Evaluation Since the surveyor's visit MALC staff entered the dates resident assessments are due in our electronic calendar. We receive an electronic message in our email (that is looked at every business day, Monday-Friday) that tells us what action is needed. We notify our nurse with at least one week's notice and she completes the assessment and ISP within the week. **Completion Date:** Electronic calendar has already been updated. We should get our first message from the electronic calendar on June 20th (assessment due no later than June 28th).	

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A 025	Continued From page 11	A 025		
	B. Review of records revealed the evaluation for resident #2 was reviewed on 11/05/09, 03/24/11 and 09/02/11. This was 1 year and 3 months from 11/05/09 to 03/24/11.			
	C. In an interview with the administrator on 09/07/11 at 12:00 pm, the administrator looked through the chart for resident #1 and did not produce any other evidence the evaluations had been reviewed at any other times than stated above and acknowledged the dates on the evaluations were 11/05/09, 03/24/11, and 09/02/11.			
A 026	7 NMAC 8.2.26 Individual Service Plan	A 026		
	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;			

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A 026	Continued From page 12 (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; (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, 7.8.2.27 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to have the Individual Service Plan (ISP) detail the services being provided by outside agencies for 2 of 2 resident charts reviewed (#1 & #2). This deficient practice has the potential for inappropriate care of the residents due to not knowing the details of the services being provided by the outside agencies. The findings are: A. Review of records for resident #1 revealed documents (visit slips) she was receiving Home Health services from a skilled agency. There was no admissions documentation from the Home Health agency in the chart or mention of the services on the ISP. B. Review of records for resident #2 revealed documents (visit slips) he was receiving Hospice services from a skilled agency. There was no	A 026	A-0026-7NMAC 8.2.26 Individual Service Plan We have added language to our contract that If a new resident is going to be admitted that is already using outside agency service that a team meeting must occur within 72 hours of the resident's admittance to MALC. In the case of a current resident be placed on services from an outside agency, the same rule will apply—MALC will call a meeting with the outside agency within 72 hours of the resident's placement for services from said agency. **Completion Date:** Contract already revised (see enclosed). To be implemented the next time we have a resident using outside services.	

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A 026	Continued From page 13	A 026		

admissions documentation from the Hospice agency in the chart or mention of the services on the ISP.

C. Review of the ISP's for residents #1 and #2 revealed no details of any services being provided by the skilled agencies.

D. In an interview with the office manager on 09/07/11 at 3:30 pm, the office manager looked through the charts for resident #1 and #2 and acknowledged there was no detailed documentation of the services being provided by the skilled agencies on the ISP's for residents #1 and #2.

This is a repeat deficiency from survey dated 04/15/09.

Based on record review and interview, the facility failed to have the Individual Service Plan (ISP) reviewed every 6 months for 1 of 2 resident charts reviewed (#1). This deficient practice has the potential for inappropriate care of the residents due to changes in needs not being addressed. The findings are:

A. Review of records on for resident #1 revealed the ISP was last reviewed by a licensed nurse on 07/24/10, over 13 months before this review of records.

B. In an interview with the administrator on 09/07/11 at 12:00 pm, the administrator looked through the chart for resident #1 and did not produce any other evidence the ISP had been reviewed since 07/24/10 and she acknowledged the finding.

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A 050	7 NMAC 8.2.50 Exits EXITS: A. The facility shall have at least two (2) approved exits, that do not involve windows and which are remote from each other. B. Facilities with ten (10) or more residents shall have each exit clearly marked with lighted signs having letters at least six (6) inches high and at least three-quarters (3/4) of an inch wide. Exit signs shall be visible at all times. C. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. D. Exits shall be clear of obstructions at all times. E. Exits, exit paths, or means of egress shall not pass through hazardous areas, garages, storerooms, closets, utility rooms, laundry rooms, bedrooms, or spaces subject to locking. F. For facilities with four (4) or more residents, sliding doors are not acceptable as a required exit. EXCEPTION: Assisted living facilities with three (3) or fewer residents may have sliding doors as required exits. G. When the yard gate(s) is part of the exit access and is locked, the gate shall be connected to the fire protection system and release upon activation of the fire/smoke system or shall have the ability to be unlocked at the gate site. [7.8.2.50 NMAC - Rp, 7.8.2.51 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to keep an approved exit to the building free from obstructions. This deficient practice has the potential for impeding exit from the building in an emergency and could affect the	A 050		

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A 050	Continued From page 15 health and safety of all eleven residents, staff and visitors to the building. The findings are: A. During a tour of the facility on 09/06/11 at 4:30 pm, an empty wheelchair was observed unattended in front of the East corridor door leading to the East approved exit. Three empty powered wheelchairs were observed stored in the East corridor exit in such a way as to impede egress to the East approved exit. B. During a tour of the facility on 09/07/11 at 2:30 pm, an empty wheelchair again was observed unattended in front of the East corridor door leading to the East approved exit. Three empty powered wheelchairs again were observed stored in the East corridor exit in such a way as to impede egress to the East approved exit. C. In an interview with the administrator on 09/07/11 at 3:00 pm, the administrator acknowledged the powered wheelchairs were being stored in the corridor leading to the exit and one of the residents leaves his wheelchair in the corridor by the door when he is in his room.	A 050	A-0050-7NMAC 8.2.50 Exits We have ordered signs and will install them by the end of next week at all MALC exits that states, "For all of our safety, all exits MUST be clear of any obstructions." In addition at the East Corridor Door we are having a more personalized sign made and will install next week that states, "XXX's wheel chair MUST be stored on the north side of pole." Storing said wheelchair north of the pole insures a minimum five feet of clearance to said exit door. All staff and residents have been advised of the importance of this law. **Completion Date:** June 29, 2012	
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated	A 068		

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program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC.
(2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms.
(3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health.
(4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members.
(5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services.
(6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure.
(7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live.
(8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination.
B. Employee training and support. A facility that provides hospice services shall provide the

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following education and training for employees who assist with providing these services:
(1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and
(2) offer an ongoing employee psychological support program for end of life care issues.
C. Individual service plan (ISP) requirements.
(1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff.
(2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following:
(a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC;
(b) what services are to be provided;
(c) who will provide the services;
(d) how the services will be provided;
(e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process;
(f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and
(g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them.
(3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in

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medication assistance or administered by the following individuals:
(a) a physician;
(b) a physician extender (PA or NP);
(c) a licensed nurse (RN or LPN);
(d) the resident if their PCP has approved it;
(e) family or family designee; and
(f) any other individual in accordance with applicable state and local laws.
D. Care coordination.
(1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC.
(2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC.
(3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation.
(a) The facility shall provide individual records for each resident.
(b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record.
(4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions.
(5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services

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shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC.
(6) The assisted living facility shall ensure the coordination of services with the hospice agency.
(a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs.
(b) The assisted living facility shall receive information and communication from the hospice staff at each visit.
(i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.).
(ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation.
(c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members.
(d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator.
(i) The process may be informal or formal depending on the nature of the issue.
(ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified.
E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements:
(1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP;

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(2) private visiting space:
(a) physical space for private family visits;
(b) accommodations for family members to remain with the patient throughout the night; and
(c) accommodations for family privacy after a resident ' s death.
F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid.
[7.8.2.68 NMAC - N, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
Refer to 7.8.2.68 B.

Based on record review and interview, the facility had one resident (#2) receiving hospice services and the facility failed to have palliative/hospice care training for all 8 staff. This deficient practice has the potential for inappropriate care of the residents admitted to hospice that retain residency at the facility. The findings are:

A. Review of records for staff #20 and #21 revealed no documentation staff had received any palliative/hospice care training.

B. In an interview with the administrator on 09/07/11 at 12:00 pm, the administrator acknowledged that none of the staff had received any palliative/hospice care training.

Based on record review and interview the facility failed to have the Individual Service Plan (ISP) detail the services being provided by a hospice

A-0068-7NMAC 8.2.68 Hospice
MALC has established a very good relationship with GRMC Hospice. They have agreed to provide 6 hours of hospice training every year, including training regarding individual residents that are placed on hospice. If GRMC Hospice is not available, then other hospice agencies are available in the area and MALC will pursue them. But to date, GRMC Hospice has fulfilled MALC's needs.
Completion Date: Documents for residents mentioned in survey have since been found. We are in the process of scanning all pertinent resident documents of current residents. This process will be completed June 29, 2012.

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agency for 1 resident chart reviewed (#2). This deficient practice has the potential for inappropriate care of the resident due to not knowing the details of the services being provided by the hospice agency. The findings are:

A. Review of records for resident #2 revealed documents (visit slips) he was receiving Hospice services from a skilled agency. There was no admissions documentation from the Hospice agency in the chart.

B. Review of the ISP's for resident #2 revealed no details of any services being provided by the hospice agency.

C. In an interview with the office manager on 09/07/11 at 3:30 pm, the office manager looked through the chart for resident #2 and acknowledged there was no detailed documentation of the hospice services being provided.

Refer to 7.8.2.68 D. Care Coordination.

Based on record review and interview, the facility failed to have hospice documentation for 1 resident receiving hospice services (#2). This deficient practice has the potential for inappropriate care of the resident due to not knowing the details of the services being provided by the hospice agency. The findings are.

A. Review of records for resident #2 revealed only visit slips from the hospice agency for the month of December, 2010, March, 2010, and April 2010. No other documentation from the hospice agency was observed in the chart for resident #2.

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	B. In an interview with the administrator on 09/07/11 at 12:00 pm, the administrator looked through the chart for resident #2 and did not produce any other documentation from the hospice agency and acknowledged resident #2 had been on hospice for about 2 years.			
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes	A 070		
	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 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: This is a repeat deficiency from survey dated 04/15/09.			
	D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC.			

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A 070	Continued From page 23 Refer to 7.1.9.8 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 submit all fees and pertinent application information to the Caregiver Criminal History Screening (CCHS) program for 1 of 2 (#21) staff within twenty (20) calendar days from the first day of employment. The findings are: A. Review of personnel records revealed staff #21 was hired on 10/07/10 and the release of information form that has to be sent to the CCHS program was not signed until 01/27/11, over 3 months from the date of hire. B. In an interview with the office manager on 09/07/11 at 3:30 pm, the office manager acknowledged that the fees and pertinent application information were not sent to the CCHS program within twenty days of the date of hire for staff #21.	A 070	A-0070-7NMAC 8.2.70 Incorporated and Related Rules and Codes Deficiency noted and rectified. After the DOH Surveyor's visit we changed our Personnel Policies to reflect that employees are required to get their fingerprints to MALC administration within the first two weeks of their employment or else their paycheck will be held until we receive them. **Completion Date:** MALC Personnel Policies have already been changed (see enclosed). We will implement with each new employee.	