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	2179	A. BUILDING: _____ B. WING _____	C 09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF SANTA FE	3838 THOMAS ROAD SANTA FE, NM 87507

(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-Onsite survey with one complaint NM00029769 on 09/17/15 for the New Mexico Requirements for Assisted Living for Adults, 7.8.2 NMAC. Complaint NM00029769 was substantiated, with no deficiencies.	A 000		
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; (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;	A 017		

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A 017	Continued From page 1 (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: 7.8.2.17 B Based on record review and interview, the facility failed to have documentation in the personnel files as required by regulation: 1.) 16 hours of supervised training to all Caregivers (CG's) prior to them providing unsupervised care for residents. 2.) 12 hours of annual training in accordance with State Regulations This deficient practice increases the potential to negatively impact all 12 (R #1-12) residents on the Resident Census List, provided by the House Manager (HM) on 09/16/15. If caregivers are providing direct care for residents and have not received the required training, then residents may not receive the care and assistance they need. The findings are: Findings related to 16 hours of supervised	A 017		

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A 017	Continued From page 2 training: A. Record review of HM's personnel file (hire date 04/23/15) revealed no documentation that she received 16 hours of supervised training prior to providing unsupervised care to residents as required in the State Regulations. B. Record review of AM's personnel file (hire date 03/28/14) revealed no documentation that she received 16 hours of supervised training prior to providing unsupervised care to residents as required in the State Regulations. C. Record review of CG #1's personnel file (hire date 03/31/15) revealed no documentation that she received 16 hours of supervised training prior to providing unsupervised care to residents as required in the State Regulations. D. Record review of CG #2's personnel file (hire date 02/09/12), revealed no documentation that she received 16 hours of supervised training prior to providing unsupervised care to residents as required in the State Regulations. E. Record review of CG #3's personnel file (hire date 04/16/15) revealed no documentation that she received 16 hours of supervised training prior to providing unsupervised care to residents since date of hire as required in the State Regulations. F. On 09/16/15 at 3:19 pm, during interview with the HM, she confirmed there is no documentation that the caregivers received the 16 hours of supervised training prior to providing unsupervised care of the residents, as required by the state regulations.	A 017		

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A 017	Continued From page 3 Findings related to 12 hours of annual training: G. Record review of AM's personnel file (hire date 03/28/14) revealed no documentation that she received 12 hours of annual training as required by State Regulations. H. Record review of CG #2's personnel file (hire date 02/09/12) revealed no documentation that she received 12 hours of annual training as required by State Regulations within the last 2 years. I. On 09/16/15 at 3:32 pm during interview with the HM, she confirmed there is no documentation in the employees personnel files that they received and completed the 12 hours of annual training as required by the state regulations.	A 017		
A 018	7 NMAC 8.2.18 Policies POLICIES: The facility shall have and implement written personnel policies for the following: A. staff, private duty attendant and volunteer qualifications; B. staff, private duty attendant and volunteer conduct; C. staff, private duty attendant and volunteer training policies; D. staff and private duty attendant and volunteer criminal history screening; E. emergency procedures; F. medication administration; G. the retention and maintenance of current and past personnel records; and H. facilities shall maintain records and files that	A 018		

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A 018	Continued From page 4 reflect compliance with NM and federal employment rules. [7.8.2.18 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.18 Based on record review and interview, the facility failed to have and implement written policies as required by the Licensing Authority for: 1.) staff qualifications, 2.) staff training, 3.) staff criminal history screening 4.) emergency procedures, 5.) medication administration 6.) the retention and maintenance of current personnel records This deficient practice has the potential to negatively affect the safety and welfare of all 12 residents (R #1-12) on Resident Census list, obtained from the House Manager (HM) on 09/16/15. If the facility does not have, implement, and ensure staff are aware of, and adhering to the facilities polices and procedures, then the residents may not receive the care and services they need, placing residents at risk for injury or illness and requiring medical intervention or treatment. The findings are: A. Record review of the facility's Policy and Procedure Manual 05/03/2012 for dietary states: personnel handling food will receive annual inservice training in food preparation, proper food storage, preparation and food storage,	A 018		

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A 018	Continued From page 5 appropriate hygiene, food stored in refrigerators is to be covered, labeled and dated, weekly menu and mealtimes will be posted, a daily log of recorded temperatures for each refrigerator and freezer will be maintained, and all garbage containers will have tight fitting lids. B. On 09/16/15 at 9:00 am during observation, Caregiver (CG #3) was in the kitchen serving food without a hairnet on. C. On 09/16/15 at 9:00 am, during interview with CG# 3, she was asked if the facility furnishes hairnets for the staff preparing and serving food to the residents she answered, "I wear my hair up so it doesn't fall in the food." D. On 09/16/15 at 09:00 am during observation, it was noted that the garbage containers did not have lids and were uncovered in the kitchen area. E. On 09/16/15 at 9:02 am during observation, no refrigerator or freezer temperature logs could be located. F. On 09/16/15 at 9:05 am during observation it was noted that an opened undated 15 ounce bottle of Teriyaki sauce was in the pantry on the shelf, its label stating "must be refrigerated after opening" and uncovered food was placed in the main kitchen refrigerator without being labeled or dated. G. On 09/16/15 at 9:05 am during observation, an opened 1 gallon container of vegetable oil and an opened 60 ounce container of non dairy creamer were observed on the kitchen counter with no date of when opened.	A 018		

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A 018	Continued From page 6 H. On 09/16/15 at 9:03 am during interview with CG# 3, when asked where the facility temperature records are for: 1.) the refrigerator, to ensure the refrigerators temperatures are maintained at 35- 41 degrees Fahrenheit (F), 2.) the freezer, to ensure freezers are maintained at or below 0 F, and 3.) the hot water temperatures to ensure that hot water temperatures are maintained at 95-110 F degrees. She stated, "I don't have any temperature logs." I. On 09/16/15 at 9:05 am during interview with Assistant Manager (AM), when asked about labeling of open food products in the refrigerator she stated, "I didn't know it had to be labeled and dated, I thought it was fine because it was in the refrigerator. J. Record review of the facility's Policy and Procedure Manual dated 05/03/2012 revealed the facility did not have or implement written policy for resident records to include: 1. being organized with a table of contents, 2. entries by direct care staff to be recorded in ink, legible, dated, and authenticated by the signature of the person making the entry related to the residents Individual Service Plan (ISP), 3. the facilities bed hold policy, 4. a complete and current resident evaluation, for each resident 5. a complete and current ISP, for each resident 6. name of dentist, 7. language spoken and understood,	A 018		

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A 018	Continued From page 7 8. documentation of incidents, 9. a complete Medication Administration Record (MAR), 10. written consent for staff to assist with medications, 11. documentation of receiving fire and safety training, 12. documentation of receiving information on reporting of incidents or unusual occurrences which has or could threaten the health, safety, or welfare of the residents. K. Record review of the facility's Policy and Procedure Manual dated 05/03/2012 for emergency plans, disasters, and training stated that Fire exit and disaster drills will be conducted at least monthly for staff and residents, a record of all drills will be documented, there will be documentation at least quarterly of a review of the emergency plan and procedures with staff and residents. No policy and procedure could be located for emergency plans to include medical emergencies, power failure, fire or natural disaster, evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas, responsibilities of personnel during emergencies, a list of transportation resources that are immediately available to transport the residents to another location in an emergency, and emergencies that affect just the facility and a region/area wide emergency. L. On 9/16/15 at 10:00 am during interview with Alternate Administrator (AA), when asked regarding the facility policy and procedure manual with regards to the missing policies and procedures, written emergency plans, policies and procedures for all emergencies, and policies and procedures that are written but not	A 018		

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A 018	Continued From page 8 implemented, he stated they receive the Policies and Procedures from the corporate office, he was unaware the facility did not have or implement all the required written policies as per the State Regulations and stated that he was currently in the process of reviewing the policies and the state regulations to implement policies, training's and compliance. M. Record review of the facility's House Reports binder revealed the last fire drill was done on 06/20/13. N Record review of the facility's Policy and Procedure Manual for fire drills dated 05/03/2012 states: Fire exit and disaster drills will be conducted at least monthly for staff and residents and a record of all drills will be documented. O. On 09/16/15 at 10:21 am during interview with the HM, when asked about monthly fire drills, she replied, "The fire drill logs are in the the House Reports binder I just gave you." (The most recent fire drill was dated 06/20/13). P. On 09/16/15 at 10:28 am during interview with the AM and CG# 3, they were asked how often fire drills should be conducted, the AM stated, "I think they need to be done every six months." CG# 3 stated, "No, I think they should be done just once a year." When asked if either had participated in a fire drill both stated, "No." Q. Record review of the facility's Policy and Procedure Manual dated 05/03/2012 for medication and oxygen storage stated the facility will ensure all medications will be stored in separate compartments for each resident, a system of records of receipt and disposition of all	A 018		

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A 018	Continued From page 9 drugs in sufficient detail to enable an accurate reconciliation, and all unused, discontinued or outdated medications will be destroyed at the next quarterly pharmacist visit and the destruction will be witnessed and documented on the drug destruction log. Policy for oxygen tank storage stated: oxygen tanks must be securely and safely stored at all times R. On 09/16/15 at 1:30 pm during observation of medication cart and medication room it was noted that the narcotic medications and the extra medications for residents are not stored in separate compartments in the medication cart for each resident, and 2 portable oxygen cylinders were noted behind the door of the medication room unsecured. S. Record review of Custodial Pharmacist binder revealed discontinued medications for December 2014, January 2015, February 2015, and March 2015 were logged to be destroyed on the next consultant pharmacist visit, remained undated, unsigned, and witnessed as destroyed and none of the listed medications could be located. T. Record review of the facility Policy and Procedure Manual for Medication Assistance Records (MAR) dated 05/03/2012 states all MAR's must include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's physician 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 018		

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A 018	Continued From page 10 (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 (by mouth, eye, ear, other); (11) the method of delivery for the medication (tablet, capsule, drops, IM (intra muscular injection) (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 PRN medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. U. Record review of the MAR for R #1-4 revealed no documentation of prescriber or residents primary care physician, the diagnosis or reason for taking the medication, and no route the medication is to be taken. V. On 09/16/15 at 1:40 pm during interview with the HM, when asked about the narcotic and the extra medication storage she replied, "The narcotics won't all fit in that small lock box if I	A 018		

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A 018	Continued From page 11	A 018		

have to separate the medications by each resident, and the extra medications aren't being used, they're just for back up and I'm sure the pharmacist took those discontinued medications, I wasn't here at that time but she always does." When asked about oxygen tank storage she replied that she has "called them [Oxygen supply company] to come pick them up several times and they never do."

W. On 09/16/15 at 1:40 pm during interview with the AA, when asked about the missing information on the MAR's he acknowledged the missing information and stated it was a "glitch" in the software program they use to create the MAR's and will ask the company (who provides the computer program) to fix it or they (the facility) will manually put any missing information on the MAR's each month.

X. On 09/17/15 at 2:00 pm during observation of medication pass, CG #2 was observed crushing medications, mixing the crushed medications with applesauce and spoon fed the mixture to R #5 in the dining room.

Y. On 09/17/15 at 2:05 pm during interview with CG #2 when asked if there were physicians orders to crush R #5's medications and mix them with apple sauce, she replied "No but the POA (power of attorney) wants us to do it this way." When asked if the POA was the primary physician, she replied "No." When asked if she had received training on crushing the medications, mixing them with apple sauce and spoon feeding the mixture to the residents, she replied "No." When asked if she had a license to administer medications she replied "No."

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A 018	Continued From page 12 Z. Record review of the facility's Policy and Procedure Manual dated 05/03/2012 for medication administration states: Only Licensed health care professionals will be responsible for the administration of medications. AA. Record review of the facility's Policy and Procedure Manual dated 05/03/2012 for staff qualifications, orientation and training states: all employees are required to go through an orientation. In addition any person providing direct personal care will be provided additional training. BB. Record review of the HM'S, AM's, CG #1, 2 and 3 personnel files revealed no documentation as proof of having received Palliative/hospice training for residents receiving hospice services. CC. Record review of HM's personnel file (hire date 04/23/15) revealed no documentation as proof of having received 16 hours of supervised training prior to providing unsupervised care to residents. DD. Record review of AM's personnel file (hire date 03/28/14) revealed no documentation as proof she received 16 hours of supervised training prior to providing unsupervised care to residents. EE. Record review of CG #1's personnel file (hire date 03/31/15) revealed no documentation as proof she received 16 hours of supervised training prior to providing unsupervised care to residents. FF. Record review of CG #2's personnel file	A 018		

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A 018	Continued From page 13 (hire date 02/09/12), revealed no documentation as proof she received 16 hours of supervised training prior to providing unsupervised care to residents. GG. Record review of CG #3's personnel file (hire date 04/16/15) revealed no documentation as proof she received 16 hours of supervised training prior to providing unsupervised care to residents since date of hire. HH. On 09/16/15 at 3:19 pm, during interview with the HM, she confirmed there is no documentation as proof the facility provided staff the 16 hours of training at orientation prior to being left unsupervised with residents, and the Palliative/hospice training for residents receiving hospice services. II. Record review of AM's personnel file (hire date 03/28/14) revealed no documentation as proof she received 12 hours of annual training as required by the State Regulations. JJ. Record review of CG #2's personnel file (hire date 02/09/12) revealed no documentation as proof she received 12 hours of annual training as required by the State Regulations within the last 2 years. KK. On 09/16/15 at 3:32 pm during interview with the HM, she confirmed there is no documentation as proof caregivers received the 12 hours of annual training and Palliative/hospice training as required by the State Regulations.	A 018		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility	A 020		

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A 020	Continued From page 14 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 (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;	A 020		

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	2179	A. BUILDING: _____ B. WING _____	C 09/17/2015

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A 020	Continued From page 15 (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: (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;	A 020		

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A 020	Continued From page 16 (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: (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	A 020		

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A 020	Continued From page 17 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 by: 7.8.2.20, A,(10) (11) Based on record review and interview, the facility failed to ensure the admission agreement for	A 020		

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A 020	Continued From page 18 residents (R #1-4) shall include notification of the residents rights and responsibilities regarding reporting of Incidents and the facility's bed hold policy. This deficient practice could lead all 12 residents (R #1-12) on Resident Census list, obtained from the House Manager (HM) on 09/16/15 to: 1) be unaware of the facility's bed-hold policy and the additional financial responsibilities associated. 2) be unaware of the requirements for reporting incidents, injuries, Abuse, Neglect, or Exploitation and at risk for not receiving assistance or medical care following an injury, injury complications if not reported and treated, and at risk for Abuse, Neglect or Exploitation. The findings are: A. Record review of residents R #1-4 facility files with regards to the Admission Agreement revealed no information on the facility bed hold policy, and no documentation as proof of receiving the information on reporting of incidents upon admission to the facility. B. Record review of the facility Policy and Procedure manual dated 05/03/2012 regarding Admissions states: (name of facility) will strictly adhere to it's Admission Policies. Prior to admission, the facility has provided the resident with and answered any questions regarding the facility Program Narrative, Rules, Admission Agreement, Bed Hold policies, Information on residents rights regarding healthcare. C. On 09/16/15 at 1:40 pm during interview with the Alternate Administrator, when asked about the missing information in the residents files, he confirmed the missing information regarding the facility bed hold policy, and the	A 020		

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A 020	Continued From page 19 Incident Reporting Requirements from the resident files and stated the Admission Agreements are sent from the corporate office and will ensure they are aware of the requirements for the Admissions Agreements and that he will be auditing and organizing the resident files, he purchased dividers for the files, and would be auditing, organizing them and completing and missing documents to ensure complaince with the state requirements as soon as possible.	A 020		
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;	A 021		

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A 021	Continued From page 20 (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 (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	A 021		

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A 021	Continued From page 21 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. 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	A 021		

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A 021	Continued From page 22 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: 7.8.2.21 A, B Based on record review and interview, the facility failed to ensure resident records are complete, maintained, and organized utilizing a table of contents, This deficient practice could likely result in a delay in care or resident harm to the 12 (R #1-12) residents on Resident Census list obtained from the House Manager (HM) on 09/16/15. If documents or important information is missing from the residents records or the record is not kept in an organized manner, than the residents may suffer a delay in treatment or care, or not receive the care or assistance they need. The findings are: A. Record review of residents R #1-4 facility files revealed: 1.) no Table of Contents for organization of documents, 2.) no Bed hold policy, 3.) no signed and dated notes by direct care staff, 4.) no dentist information 5.) no Medication Administration Record (MAR), B. Record review of the facility Policy and	A 021		

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A 021	Continued From page 23 Procedure Manual dated 05/03/12 regarding resident records states: each resident record is to be maintained and organized utilizing a table of contents and shall include: 1. entries will be recorded in ink, legible, dated, and authenticated by the signature of the person making the entry. 2. the facility bed hold policy, 3. name of dentist, 4. language spoken and understood, 5. documentation of incidents, 6. a complete Medication Administration Record (MAR), 7. written consent for staff to assist with medications, C. On 09/16/15 at 1:40 pm during interview with the Alternate Administrator (AA), when asked about the missing information in the residents files, he confirmed the missing information and stated he was in the process of auditing the residents files and he purchased tab dividers for the resident files, the facility would be organizing them as soon as possible, the nurse reviews the resident evaluations and ISP's online, the information is kept on the computers and just need to be printed once the nurse reviews them.	A 021		
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing	A 022		

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A 022	Continued From page 24 authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained; (7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction; (8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks; (9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSES) rating, if applicable; (10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another	A 022		

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A 022	Continued From page 25 location in an emergency; the emergency preparedness plan shall address two types of emergencies: (a) an emergency that affects just the facility; and (b) a region/area wide emergency; (11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC); (12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and (13) vaccination records for pets in the facility. B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority: (1) a copy of the facility license; (2) employee personnel records, including an application for employment, training records and personnel actions: (a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC; (b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and (3) a copy of all waivers or variances granted by the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (3) resident use of television, radio, stereo and cd;	A 022		

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A 022	Continued From page 26 (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas; (7) accommodation of resident ' s pets; and (8) resident use of electric blankets and appliances. D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas: (1) actions to be taken in case of accidents or emergencies; (2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission; (3) policy for medication errors; (4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.); (5) the handling of resident's funds, if the facility provides such services; (6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (12) admission agreement; (13) admission records;	A 022		

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A 022	Continued From page 27 (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (9) (10), B (2). D (2) (6) (7) (9) (11) (14) (22) (23) Based on record review and interview, the facility failed to: 1.) keep accurate and complete facility reports, records, rules, policies and procedures	A 022		

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(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 022	Continued From page 28 and 2.) ensure required trainings are completed for all employees at orientation and yearly to include the facility policy and procedures. This deficient practice has the potential to negatively impact all 12 (R #1-12) residents on then Resident Census list, obtained from the House Manager (HM) on 09/16/15. If the facility is not conducting monthly fire drills than the residents are at risk for harm or death should there be a fire, the staff are not prepared to respond, help as needed, and assist the residents to evacuate the facility. If the facility does not ensure all staff are receiving orientation and training upon hiring (on all the required trainings, policies and procedures), then the residents are at risk for harm due to staff not having the required information to ensure resident health, safety and welfare. The findings are: A. Record review of the facility's House Reports Binder revealed: 1. no record of monthly fire drills 2. no written emergency plans, policies and procedures for power failure, fire or natural disaster; emergency equipment, refuge areas and the responsibilities of personnel during emergencies; no list of transportation resources that are immediately available to transport the residents to another location in an emergency; 3. no emergency preparedness plan for emergencies that affect just the facility, 4. no emergency preparedness plan for region/area wide emergencies, 5. no documentation as proof of providing staff and resident fire and safety training; B. Record review of the facility's Policy and Procedure Manual dated 05/03/12 for emergency	A 022		

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A 022	Continued From page 29 plans, disasters, and training stated that Fire exit and disaster drills will be conducted at least monthly for staff and residents, a record of all drills will be documented, there will be documentation at least quarterly of a review of the emergency plan and procedures with staff and residents. C. Record review of residents R #1-4's facility files revealed no documentation as proof that the residents and their family received Fire and Safety Training. D. On 9/16/15 at 10:00 am during interview with Alternate Administrator (AA), when asked regarding missing emergency plans, policies and procedures, and trainings, he stated they receive the Policies and Procedures from the corporate office, was unaware the facility did not have and had not implemented all the required written policies and emergency plans, he was unaware of any missing training records, and he stated that he was currently in the process of reviewing the facility policies and all employee and resident records for compliance and to implement any missing trainings. E. On 09/16/15 at 10:21 am during interview with the House Manager (HM), when asked about the required monthly fire drills, she replied, "The fire drill logs are in the House Reports binder I just gave you." (The most recent fire drill was dated 06/20/13). F. On 09/16/15 at 10:28 am during interview with the Assistant Manager (AM) and Caregiver (CG# 3), they were asked how often fire drills should be conducted, the AM stated, "I think they need to be done every six months." CG# 3	A 022		

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A 022	Continued From page 30 stated, "No, I think they should be done just once a year." When asked if either had participated in a fire drill both stated, "No." Findings Related to Fire and Safety training: G. Record review of the HM's, AM's and CG #1, 2 and 3 personnel files revealed no documentation as proof of having received Fire and Safety training. H. On 09/16/15 at 3:19 pm the HM confirmed there is no documentation that training was provided or completed in the employee personnel files.	A 022		
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,	A 025		

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A 025	Continued From page 31 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 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]	A 025		

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A 025	Continued From page 32 This REQUIREMENT is not met as evidenced by: 7.8.2. 25 A, B, C, E Based on record review and interview, the facility failed to ensure that Resident Evaluations are documented on a resident evaluation form, are complete to include signatures and dates of the nurse who reviewed the evaluations for 4 of 4 residents (R #1-4) sampled for compliance. This deficient practice has the potential for residents to not receive the appropriate care and assistance they need upon admission and as changes in their health status occurs due to the evaluations not being accurately completed and reviewed as required. The findings are: A. Record review of residents (R #1-4) evaluations revealed: 1.) no current signatures or dates of the person who completed the resident assessment or the nurse who reviewed the evaluation. 2.) The evaluations did not address at a minimum the following abilities, behaviors or status: (1) activities of daily living and the level of assistance needed, who will provide the assistance, how will the assistance be provided, when and where the assistance will be provided (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, (3) communication and hearing; ability to	A 025		

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A 025	Continued From page 33 communicate needs and understand instructions, (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. B. On 09/16/15 at 1:40 pm during interview with the Alternate Administrator, when asked about the resident evaluations, the required information and who completes the resident evaluation, he stated the House Manager completes them, the nurse reviews them online, they are kept in the computer system and just need to be printed once the nurse reviews them.	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	A 026		

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A 026	Continued From page 34 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; (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, B Based on record review and interview, the facility	A 026		

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A 026	Continued From page 35 failed to ensure: 1.) the Individual Service Plans (ISP) were complete, accurate, to include signatures of residents or their family as being included in the developement of the ISP, 2.) signatures of person completing the ISP's, 3.) dates of when the ISP's are completed, and 4.) the ISP's shall address those areas of need as identified in the resident evaluation for 4 of 4 residents (R #1-4) sampled for compliance. This deficient practice has the potential for residents to not receive the appropriate care and assistance they need upon admission and as changes in their health status occurs due to the ISP's not being accurately completed and reviewed as per the State Regulations. The findings are: A. Record review of residents (R #1-4) ISP's revealed the ISP's: 1.) did not address all the areas of need as identified in the resident evaluation, 2.) contain no signature of the resident or the family as having input or being aware of the assistance being provided to the resident, 3.) have no signature of the person completing the ISP 4.) have no current dates of when the ISP was completed, 5.) are not being filed in residents record, 6.) do not detail the services that are provided by the facility as well as the services to be provided by other agencies, to include: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided;	A 026		

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A 026	Continued From page 36 (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. B. Record review of the facility policy and procedure dated 05/03/12 for the ISP revealed: The ISP will meet the requirements of the State Regulation, including what services will be provided, who will provide the service, how the service will be provided and list the staff involved in the ISP. C. On 09/16/15 at 1:40 pm during interview with the Alternate Administrator (AA), when asked about the ISP's, the required information and who implements the ISP's following the resident evaluation, he stated the House Manager completes them, the nurse reviews them online, and they are kept in the computer until the nurse reviews them.	A 026		
A 027	7 NMAC 8.2.27 Resident Activities RESIDENT ACTIVITIES: Each facility shall provide or make available recreational and social	A 027		

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A 027	Continued From page 37 activities appropriate to the residents ' abilities that meet their psychosocial needs and are relevant to their social history; including a balance of cognitive, reminiscence, physical and social activities. The facility shall post the activities and encourage residents to participate. [7.8.2.27 NMAC - Rp, 7.8.2.28 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.27 Based on observation and interview, the facility failed to post an activities program or calendar to meet the needs of all 12 (R #1-12) residents, on resident census list provided by the House Manager (HM) on 09/17/15. This deficient practice has the potential to affect the psychosocial well being of the residents through decreased engagement, socialization and stimulation. The findings are: A. On 09/17/15 at 9:15 am during observation, it was noted that no Activities Calendar was posted in any of the common areas of the facility. B. On 09/17/15 at 9:05 am during interview with the House Manger, when asked where the current months Activities Calendar is posted, she replied "It's right there on the desk" (referring to the desk calendar on the desk in the medication room/House Managers Office.) they can come in here and see it if they want to."	A 027		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall	A 033		

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A 033	Continued From page 38 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 services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary	A 033		

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A 033	Continued From page 39 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 informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the	A 033		

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A 033	Continued From page 40 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: 7.8.2.33 D (3), (11) (j)	A 033		

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A 033	Continued From page 41 Based on record review and interview the facility failed to: 1) provide residents written information about all services provided by the facility 2) ensure residents the right to participate in the development of their care plan/Individual Service Plan (ISP) for 4 of 4 residents (R #1-4) residents sampled for compliance. This deficient practice could result in the residents not knowing what services the facility provides and the associated financial responsibility. If the facility is not including residents or their families when completing the ISP's then residents may not be receiving the care and assistance they need with activities of daily living. The findings are: Findings related to services provided by the facility: A. Record review of R # 1-4's facility files revealed no information on the facility Bed Hold Policy. B. Record review of the facility Policy and Procedure regarding Admissions dated 05/03/12 states:(Name of facility) will strictly adhere to it's Admission Policies. Prior to admission, the facility has provided the resident with and answered any questions regarding the facility Program Narrative, Rules, Admission Agreement, Bed Hold policies, and information on residents rights regarding healthcare. Findings related to ISP: C. Record review of residents R #1-4's ISP's revealed no signature of the resident or the	A 033		

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A 033	Continued From page 42 family participating in, having input or being aware of any assistance being provided to the resident. D. Record review of the facility policy and procedure for the ISP dated 05/03/12 revealed: The ISP will meet the requirements of the State Regulation, including what services will be provided, who will provide the service, how the service will be provided and list the staff involved in the ISP. E. On 09/16/15 at 1:40 pm during interview with the Alternate Administrator (AA), when asked about the missing information in the residents files and the ISP's, he acknowledged the missing information and stated he was in the process of auditing the resident files, he purchased dividers for the files, would be organizing them as soon as possible. He stated the House Manager completes the ISP's, the nurse reviews them online, the information is kept online in the facility computer program and can be printed them out once they have been reviewed by the nurse.	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 obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications	A 034		

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A 034	Continued From page 43 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 shall document: (a) the type and strength of the schedule II through IV drugs;	A 034		

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A 034	Continued From page 44 (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 reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications.	A 034		

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A 034	Continued From page 45 (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: Reference 7.8.2.34 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. Other nonflammable (inert) medical gases may be stored in the enclosure.	A 034		

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A 034	Continued From page 46 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)].	A 034		

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A 034	Continued From page 47 Based on observation, record review and interview, the facility failed to ensure correct medication and oxygen storage, ensure that any remaining medication discontinued by a physician's order, upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container until they can be destroyed on the next quarterly visit from the consulting pharmacist. If the facility does not ensure medications are stored correctly then all 12 residents (R #1-12) on the Resident Census list, obtained from the House Manager (HM) on 09/16/15 could be at risk for taking another residents medications and could suffer adverse side effects. If oxygen tanks are not safely secured, they may be struck or inadvertently knocked over causing an explosion or fire. 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. The findings are: A. On 09/16/15 at 1:30 pm, during observation of medication cart and medication room it was noted that the Narcotic medications and the extra medications for residents are not stored in separate compartments in the medication cart for each resident, and there were 2 portable oxygen cylinders standing behind the door to the medication room unsecured. B. Record review of Custodial Pharmacist binder revealed: 1. discontinued medications logged in for the months of December 2014, January 2015, February 2015, and March 2015 to be destroyed by the Consultant Pharmacist on the next Quarterly visit.	A 034		

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A 034	Continued From page 48 2. the consultant pharmacist made visits in January 2015, March 2015, and on 06/30/15 and failed to sign the medication distraction sheets stating the medications had been destroyed. C On 09/16/15 at 1:30 pm, during observation of the locked storage container for medications to be destroyed, there were no medications pending destruction that could be located. that medication he last consultant pharmacist visit was on 06/30/15, and previous visits took place in March 2015, and January 2015. The medication destruction sheets remain unsigned indicating the medications have not yet been destroyed yet no medications could be located in the facility as discontinued and pending destruction by the Consultant Pharmacist. D. Record review of the facility's Policy and Procedure Manual dated 05/03/2012 for Medication stated that all medications will be stored in separate compartments for each resident, a record of receipt and disposition of all drugs will be maintained, all unused, discontinued or outdated medications will be destroyed at the next quarterly pharmacist visit and the destruction will be witnessed and documented on the drug destruction log. Policy for oxygen tank storage dated 05/03/2012 stated: oxygen tanks must be securely and safely stored at all times. E On 09/16/15 at 1:40 pm, during interview with the HM when asked about narcotic and extra medication storage she replied "Then the narcotics won't all fit in that small lock box if I have to separate each residents medications,	A 034		

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A 034	Continued From page 49 and the extra medications aren't being used, they're for back up" and I'm sure the pharmacist took those discontinued medications, I wasn't here at that time but she always does." When asked about oxygen tank storage she replied that she has "called them (oxygen company that supplies oxygen) to come pick them up several times and they never do."	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.	A 035		

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A 035	Continued From page 50 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 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;	A 035		

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A 035	Continued From page 51 (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; (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	A 035		

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A 035	Continued From page 52 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 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 G(6,17) Based on observation, record review, and	A 035		

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A 035	Continued From page 53 interview the facility failed to: 1. ensure a signed consent is obtained from residents or their family for the facility to assist with the self administration of medications, and 2. ensure the Medication Administration Record (MAR) is accurate, complete, and in the residents facility file, for 4 residents (R #1-4) of 12 (R #1-12) on the resident census list provided by the House Manager (HM) on 09/16/15. This deficient practice could result in residents receiving assistance with the self administration without their consent. If information on the MAR is not complete and accurate this could result in medication errors resulting in harm or the need for medical treatment. If the MAR is not being kept in the residents file as required then medications may not be reviewed, updated or changed correctly by physicians or other consultants when visiting the facility. The findings are: Findings related to consent to assist with medications: A. Record review of residents R #1 and R # 4 facility records revealed no signed consent for staff to assist with the self administration of medications. Findings related to the MAR: B. Record review of the electronic printed version of the MAR, as there is no copy of any MAR's in the residents file for R #1-4 revealed: no documentation of the diagnosis listed for the medications ordered, no doctors name or prescriber information, no route of delivery, no maximum number of doses that may be given in a 24-hour period for PRN(as needed)	A 035		

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A 035	Continued From page 54 medications, the circumstances in which a PRN medication is to be used, the number of doses that may be given in a 24 hour period and under what circumstances the primary care practitioner is to be notified. C. Record review of the facility's Policy for MAR's dated 05/03/12 states all MAR's must include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's physician 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; (6) notation if the medication is a schedule II-IV drug (a controlled substance narcotic easily abused and must be signed out each time given); (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 (by mouth, eye, ear, other); (11) the method of delivery for the medication (tablet, capsule, 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;	A 035		

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A 035	Continued From page 55 (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. D. On 09/16/15 at 1:40 pm, during interview with the Alternate Administrator (AA), he confirmed the missing consents to assist with the self administration of medications, and stated that the facility would be auditing all records for compliance with the regulations. Regarding the missing information on the MAR's he stated that it was a "glitch" in the software program they (the facility) use, he states the information is not populating onto the MAR. He will ask the company (who provides the computer program) to fix it or they (the facility) will manually put any missing information on the MAR's each month.	A 035		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements.	A 036		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF SANTA FE	3838 THOMAS ROAD SANTA FE, NM 87507

(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 036	Continued From page 56 (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food;	A 036		

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A 036	Continued From page 57 (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that	A 036		

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A 036	Continued From page 58 include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables	A 036		

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A 036	Continued From page 59 or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water	A 036		

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A 036	Continued From page 60 back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2. 36 A (1d), C (d 4 and 5)	A 036		

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A 036	Continued From page 61 Based on observation, record review, and interview, the facility failed to ensure sanitary practices during meal service, ensuring all garbage and kitchen refuse that is not disposed of through a garbage disposal unit is kept in watertight containers with close-fitting cover, maintain a daily log of the recorded temperatures for all facility refrigerators and freezers, provide menus to include meal substitution options and therapeutic diets, and adhere to proper food storage practices by: 1) Not ensuring that staff were using hairnets or caps and disposable gloves while in the kitchen. 2) Not ensuring all garbage and kitchen refuse that is not disposed of through a garbage disposal unit is kept in watertight containers with close-fitting cover. 3) Not maintaining a daily log of the recorded temperatures for all facility refrigerators and freezers. 4) Not posting menus which are to include alternate choices. 5) Not ensuring that all open food is labeled and dated in accordance with safe food storage practices. This deficient practice has the potential to affect all 12 residents (R #1-12) on Resident Census list, obtained from the House Manager (HM) on 09/16/15. If safe food handling practices is not adhered to this can lead to food related illnesses and/or contamination. If menus and alternate	A 036		

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A 036	Continued From page 62 meal choices are not posted the residents and their families are not informed as to what other options are available for resident's to eat if they are unable to eat the primary menu item. The findings are: Findings related to food safety and sanitary practices: A. On 09/16/15 at 9:00 am during observation, Caregiver (CG #3) was in the kitchen serving food without a hairnet on and not wearing gloves. B. On 09/16/15 at 9:00 am, during interview with CG# 3, she was asked if the facility furnishes hairnets for the staff preparing and serving food to the residents she answered, "I wear my hair up so it doesn't fall in the food." C. On 09/16/15 at 09:00 am during observation, it was noted that the garbage containers did not have lids and were uncovered in the kitchen area. Findings related to daily temperature logs: D. On 09/16/15 at 9:02 am during observation, no refrigerator or freezer temperature logs were located. E. On 09/16/15 at 9:03 am during interview with CG# 3, when asked where the temperature logs were located for the refrigerator and the freezer, she stated, "I don't have temperature logs for either one." Findings related to safe food storage practices	A 036		

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A 036	Continued From page 63 F. On 09/16/15 at 9:05 am during observation, it was noted that food was placed in the main kitchen refrigerator without being labeled or dated. G. On 09/16/15 at 9:05 am during interview with Assistant Manager (AM), when asked about labeling of open food products in the refrigerator she stated, "I didn't know it had to be labeled and dated, I thought it was fine because it was in there." Findings related to menus and alternate choices: H. On 09/16/15 at 9:10 am during observation, it was noted that no menu or menu alternatives was posted in view of residents and visitors. I. Record review of the facility's Policy and Procedure Manual on 09/16/15 for dietary states: personnel handling food will receive annual inservice training in food preparation, proper food storage, preparation and food storage, appropriate hygiene, food stored in refrigerators is to be covered, labeled and dated, weekly menu and mealtimes will be posted, a daily log of recorded temperatures for each refrigerator and freezer will be maintained, and all garbage containers will have tight fitting lids. J. On 09/16/15 at 9:15 am during interview with the AM and CG# 3, when asked about the weekly menu being posted, CG# 3 stated, "I put it here on the refrigerator" (referring to the one in the kitchen), [signs are posted stating only employees are allowed in the kitchen] and I write the meals for the day on the chalk board in the dining room. The AM stated, "I didn't know we	A 036		

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A 036	Continued From page 64 had to put a weekly menu out for the residents to see."	A 036		
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath	A 037		

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A 037	Continued From page 65 towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet. B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.37 (6), (7) Based on observation, record review and interview, the facility failed to keep soiled linen separate from clean linen, ensure linens are kept in a clean well ventilated storage area, and hazardous chemicals are locked up. This deficient practice may cause harm to the 12 residents (R #1-12) on the resident census provided by the House Manager on 09/16/15. If the soiled linen is not kept separate from clean linen, and if clean linens are not stored correctly, then residents may suffer illness from contaminated linens. If laundry and cleaning supplies are not secured correctly then residents may inadvertently ingest, or come into contact with laundry and cleaning supplies becoming ill and needing medical intervention. The findings are:	A 037		

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A 037	Continued From page 66 A. On 09/16/15 at 9:05 am, during observation of the clean linen storage closet it was noted that bags of dirty linen, a vacuum cleaner and other hygiene products were stored in the clean linen storage closet that was not ventilated. B. Record review of the facility Policy and Procedure dated 05/03/12 for clean linens states: A separate, dry, well ventilated storage area for clean linen is provided. C. On 09/16/15 at 9:10 am, during observation of the laundry room, it was noted that the door was unlocked and on the counter top were containers of bleach, laundry detergent, Windex glass cleaner, Pine-sol cleaner, and a clear unlabeled plastic spray bottle with a clear liquid inside. D. Record review of the Employee Policy for hazardous chemicals dated 05/03/12 states: Hazardous chemicals will be locked up at all times when not being used by the (name of facility) staff. E. On 09/16/15 at 10:00 am, during interview with the Alternate Administrator, when asked about the dirty linen, vacuum cleaner and hygiene products being stored in the unventilated clean linen closet, he replied that the dirty linens are in bags and he was unaware there had to be ventilation. When asked about the storage of laundry and cleaning supplies, he replied he was unaware they were not stored securely.	A 037		
A 043	7 NMAC 8.2.43 Hazardous Areas	A 043		

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A 043	Continued From page 67 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 68 This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.43 A. (3) Based on observation and interview, the facility failed to ensure the self closing device on the laundry room door was functioning. This deficient practice could lead to harm to all 12 residents on the resident census list provided by the House Manager on 09/16/15, should there be a fire in this hazardous area. The findings are: A. On 09/16/15 at 1:21 pm, during observation it was noted the facility laundry room does not latch shut despite the self closing device. Further inspection of the laundry room revealed it was equipped with 2 natural gas fuel fired dryers; thus qualifying the room as a hazardous area. B. On 09/16/15 at 1:45 pm, during interview with Caregiver (CG# 3) she confirmed the laundry room door does not latch shut, stating, "It should close all the way."	A 043		
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	A 065		

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A 065	Continued From page 69 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 interviews, the facility failed to ensure that fire drills are being conducted on each eight (8) hour (day, evening, night) shift, per quarter that employs the use of the fire alarm system or the detector system in the facility. This failed practice could result in staff not being adequately prepared to exercise their duties in accordance with the facility's fire evacuation plan in the event of fire, which presents the risk of potential harm to all 12 (R #1-12) residents as identified by the resident census list provided by the House Manager (HM) on 09/16/15. The findings are: A. Record review of the facility's House Reports binder revealed the last fire drill was conducted on 06/20/13. B. On 09/16/15 at 10:21 am, during interview with the HM, when asked about monthly fire	A 065		

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A 065	Continued From page 70 drills, she replied, "The fire drill logs are in the the House Reports binder I just gave you." C. On 09/16/15 at 10:28 am, during interview with the Assistant Administrator (AM) and Care Giver (CG) # 3, they were asked how often fire drills should be conducted, the AM stated, "I think they need to be done every six months." CG# 3 stated, "No, I think they should be done just once a year." When asked if either had participated in a fire drill both stated, "No."	A 065		
A 066	7 NMAC 8.2.66 Staff and Resident Fire and Safety Training STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff of the facility shall know the location and the proper use of fire extinguishers and the other procedures to be followed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff shall be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident admitted to the facility shall be given an orientation tour of the facility to include the location of the exits, fire extinguishers and telephones and shall be instructed in the actions to be taken in case of fire or other emergencies. D. Fire drill procedures. The facility must conduct at least one (1) fire drill each month.	A 066		

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A 066	Continued From page 71 (1) Fire drills shall be held at different times of the day, evening and night. (2) The fire alarm system or detector system in the facility shall be used in the fire drills. During the night, the fire drill alarm may be silenced. (3) During the fire drills, emphasis shall be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall show the date and time of the drill, the number of personnel participating in the drill, any problem(s) noted during the drill and the evacuation time in total minutes. (5) The local fire department may be requested to supervise and participate in the fire drills. [7.8.2.66 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.66 Based on record review and interview, the facility failed to conduct Fire and Safety training for staff and residents to assure preparedness for fire or an emergency. This deficient practice presents a risk of harm to all 12 (R #1-12) residents on the resident census list, provided by the House Manager on 09/16/15. If staff is not trained on fire and safety procedures then they will not know what to do and how to assist the residents in case of fire or other emergency. If residents are not provided the information on fire and safety, then they will not know what to do should there be a fire or other emergency resulting in injury or harm. The findings are:	A 066		

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A 066	Continued From page 72 A. Record review of House Manager (HM), Assistant Manager and Caregivers # 1-3 personnel files, revealed no documentation that they received Fire and Safety Training. B. Record review of residents R #1-4 facility files revealed no documentation that the resident and their family received Fire and Safety Training. C. Record review of the facility's Policy and Procedure Manual dated 05/03/12 for fire drills states: Fire exit and disaster drills will be conducted at least monthly for staff and residents and a record of all drills will be documented. D. On 09/16/15 at 10:28 am, during interview with the Assistant Manager(AM) and Care Giver (CG) # 3, they were asked how often fire drills should be conducted, the AM stated, "I think they need to be done every six months." CG# 3 stated, "No, I think they should be done just once a year." When asked if either had participated in a fire drill both stated, "No."	A 066		
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	A 068		

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A 068	Continued From page 73 any other entity which provides a coordinated 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.	A 068		

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A 068	Continued From page 74 B. Employee training and support. A facility that provides hospice services shall provide the 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.	A 068		

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A 068	Continued From page 75 (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in 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	A 068		

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A 068	Continued From page 76 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 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	A 068		

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A 068	Continued From page 77 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; (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: 7.8.2.68 B (1) Based on record review and interview, the facility failed to provide training for employees who assist with providing hospice services, which includes a minimum of 6 hours per year of palliative (comfort care)/hospice care training, 1 hour specific to the hospice resident's Individual Service Plan (ISP) for 2 residents (R #2, 3) of 12 (R #1-12) identified as receiving hospice services by the Administrator on 09/16/15. This deficient practice could result in the residents not receiving the palliative or the end of life care they need if staff are not provided the appropriate hospice training. The findings are:	A 068		

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A 068	Continued From page 78 A. Record review of the House Manager (HM)'s, Assistant Manager's (AM) and caregiver (CG #1, 2 and 3) personnel files, revealed no documentation that they received the required additional 6 hours of Palliative/hospice training. B. On 09/16/15 at 3:19 pm, during interview with the HM, she confirmed there is no documentation as proof in the staff personnel files that they received the palliative/hospice training.	A 068		