Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5772	A. BUILDING _____ B. WING _____	C 06/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADOBE ASSISTED LIVING #1 (THE)	1111 E MOUNTAIN LAS CRUCES, NM 88001

(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 01	OPENING REMARKS The following deficiencies were cited on 06/18/09 as a result of a Complaint Survey (complaint # 27142) for 7.8.2 NMAC, Requirements for Adult Residential Care Facilities.	A 01		
A22	7 NMAC 8.2.22 Resident Records 7.8.2.22 RESIDENT RECORDS: A. RESIDENT RECORDS, CONTENTS: A record for each resident shall be maintained with specific information required. Entries in each resident's record shall be legible, dated, and authenticated by the signature of the person making the entry. Resident records must include: (1) Admission records as set out in Section 7.8.2.21 NMAC: (2) Within five (5) days of admission: (a) An executed admission agreement. (b) A completed resident assessment form. (c) Any available, admission physical examination report by a licensed health care professional, which may include all discharge information from another facility. When admission follows within thirty (30) days discharge from an acute care hospital, the hospital history and physical report, and the hospital discharge summary may serve as an admission physical. (d) Names, addresses, relationship, and phone numbers of family members, and where appropriate, guardians, agents, and any surrogate decision makers. (3) Within thirty (30) days of admission: (a) A admission physical examination report by a licensed health care professional if an examination report was not available within five (5) days of admission. (b) Resident's name, age, recent photograph, social security number, marital	A22	Scanned 7/9/09 JH	

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JUL 2009
HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

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

TITLE: Director

(X6) DATE: 7/3/09

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A22	Continued From page 1 status, date of birth, sex, address prior to admission, religion (optional), personal physician, dentist, social history and designated representative or other emergency contact person, language spoken and understood, legal documentation relevant to commitment and/or guardianship status, present medications, and diet required. (c) Any amendments to the admission agreement. (d) The current completed resident assessment form. (e) A completed and current individual service plan. (f) Entries by direct care staff, appropriate health care professionals, or others authorized to care for the resident. Entries shall be dated and signed by the person making the entry and shall include significant information related to the individual service plan. (g) Entries providing a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention, and entries reflecting appropriate follow-up. The maintenance of such written record in the resident record may be by copy of an incident/accident report, if the original incident/accident report is maintained elsewhere by the facility. (h) A medication record: Medications administered by licensed personnel and/or staff assisting with medications to include: listing all currently ordered medications by name, dosage, administration times; documenting by medication name, dosage, date, and time, each medication administered, with the initials of the individual who administered or assisted with the	A22		

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A22	Continued From page 2	A22		

medication; documentation of errors, omissions, and side-effects of medications; and written consent by resident or guardian for staff to assisting with medications.

(i) Date, time and progress note of health services provided by any contract agency.

(j) Unless included in the admission 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.

(k) Transfer forms completed, signed, and provided to accepting facility when resident is transferring to a hospital or another health care facility.

(l) Documentation of disposition of the resident's personal effects and money or valuables deposited with the adult residential care facility, upon death or transfer.

B. RESIDENT RECORDS, MAINTENANCE:

(1) Resident records shall be maintained and stored in an organized, accessible and permanent manner.

(2) The facility shall establish a policy for maintaining, and confidentiality of resident records, including the authorized release of resident records.

(3) Resident records must be maintained by the facility against loss, destruction, and unauthorized use for a period of not less than three (3) years from the date of discharge.

(4) There must be a policy and procedure in place for record retention in the event of facility closure.

[7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 7.8.2.22 NMAC - Rn 7 NMAC 8.2.22, 8-31-00]

This REQUIREMENT is not met as evidenced

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A22	Continued From page 3 by: NMAC 7.8.2.22 (A.3.g.) Based on record review and interview, the facility failed to maintain records of the removal and monitoring of a mole, medical appointments, and follow-up related to suspected injury for 1 of 3 (Resident #1) sampled residents. The findings are: A. Resident #1 was admitted to the facility on May 27, 2005 with diagnoses of hypertension and diabetes mellitus type II. B. Review of the chart regarding removal and monitoring of the mole revealed the following: 1. Physician's Progress Notes dated 01/05/09 revealed a referral to a Dermatologist. There was a handwritten entry indicating an appointment was scheduled for 01/07/09. 2. Review of Nurses Notes from January 2009 to June 2009 revealed no entries related to the removal of the mole, any discharge instructions or monitoring of the mole. 3. Review of a "Resident Assessment" dated 05/07/09 revealed no areas of concern identified under, "Skin Condition." C. Review of the chart regarding medical appointments revealed a form titled, "Outside MD [Doctor]/Clinician Visit Log." There were no entries after 03/26/09. D. Review of the chart regarding a suspected injury revealed the following: 1. Review of "Potential Change In Condition Notification" forms dated 05/24/09, a handwritten entry by Caregiver #3, "It appears that [Resident #1]'s face is a little swollen. Mostly her right side of her face and her eyes." Under "Action taken,"	A22	A22 B 1 – 3 Staff will be in-serviced on making sure when residents are picked up from a Dr. appt. or are brought back to the facility by a family member that they receive all appropriate information concerning the resident, such as follow up appts. and any discharge instructions. These documents will be given to the Med Assistant who will stamp the form "Received." Copies will be distributed to the Administrator and nurse. When filing documentation in the resident chart the Outside Doctor/Clinician Visit Log will also be completed along with documentation in the nurse's notes. The administrator will monitor this for completion monthly when doing the monthly chart audits. Cont.....	7/10/09 7/10/09

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A22	Continued From page 4 an entry by the Registered Nurse (RN), "Phy [Physician] called/assessed L [left] knee therapist assessed able to do therapy c/ [with] her. Possible x-ray. No bruising or redness. Pain level 7 (scale 1-10)." On 05/25/09, a handwritten entry by a Caregiver no longer employed noted, "On 05/24/09, [Resident #1] fell with staff and the 05/25/09 noticed [sic] left leg swollen and left hand and wrist swollen. and [sic] left wrist pain. When asked by staff she refused to go to the hospital. Says she will see her own Doctor." 2. Review of Nurses Notes for May 2009 and June 2009 revealed no entries or assessments of Resident #1's condition regarding a swollen face, leg, hand or wrist. There were no entries regarding an appointment with Resident #1's Physician related to the swelling or pain. 3. Review of an x-ray report dated 05/29/09, revealed x-rays were taken of Resident #1's right and left hip, lower spine and right knee. E. On 06/17/09 at 10:13 am, during an interview, the Assistant Administrator was shown the log for Resident #1's Doctor's appointments and asked where the entries were after 03/26/09. She stated, "The girls haven't been writing it in...I don't know." When asked why there were x-rays of the right side of Resident #1's body and the hips when there were suspected injuries to the left side of the body, the Assistant Administrator stated, "I don't know." The Assistant Administrator was asked where the documentation was of any assessment or response to the Change of Condition forms alleging Resident #1 had swelling of the face and left leg, left hand and left wrist. She stated, "If she [the Registered Nurse] assessed [Resident #1], it should be documented." When asked why the Registered Nurse (RN) was documenting information about the left knee on the Change of	A22	A 22 Cont. Upon receiving incident reports, change in condition or Dr. orders the nurse will determine if the resident needs short or long term monitoring at that times. These reports will be kept in a binder titled, On Going Monitoring. Nurse will also at that time update the Assessment and the Service Plan for the resident. She will review these reports at least weekly. Upon completing that update the Administrator will review it and sign off on the Service Plan. Once the issue requiring additional monitoring is resolved, the nurse will document such information in the resident's chart and remove the report from the On Going Monitoring Book. Staff will be re-in serviced on the proper procedure for completing and turning in incident and change in condition reports. a. Complete before end of shift b. Turn in to Administrator c. Administrator review and put in nurses box	7/10/09 7/10/09

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A22	Continued From page 5 Condition form alleging swelling of the face, she stated, "[The Administrator]'s going to have to look into this." F. On 06/17/09 at 2:30 pm, during an interview, the Administrator reported she could not find any documentation but the referral for the mole in Resident #1's chart. She reported she had no knowledge or information regarding any change in condition regarding the area where the mole had been removed. She stated that the log for Doctor appointments had not been completed as required. When asked about the reports of swelling to the face, leg, hand and wrist, the Administrator stated she had never seen the Change of Condition reports alleging swelling. G. On 06/17/09 at 3:00 pm, during an interview, the RN joined in the interview with the Administrator and reported she did not know anything about a mole on Resident #1's back. She further stated she had not seen the Change of Condition report related to a fall and stated, "I almost always write something on these." When asked where her charting was of Resident #1's condition and the monitoring after the fall, the RN reported, "I should have charted it." She further admitted, "A lot of times I go to the recent Incident Reports and check on people but I don't chart it." H. On 06/17/09, the Administrator was asked to provide proof of contact of the Physician per the Resident's request after the fall and complaints of pain as none could be found in the chart. On 06/18/09, the Administrator provided a copy of a Physician's Progress Note dated 05/28/09 under an earlier entry dated 05/15/09 that was not previously in the chart. In the original chart, the 05/15/09 entry did not have any additional	A22	Nurse will assess and document on report the resident status. If there is a condition requiring continued monitoring a copy will be made and put in the On Going Monitoring Book until the issue is resolved. Nurse has also been provided with a Rapid Memo Communication Book to be used in documenting all calls and communication between her and any doctors. A copy will be placed in resident chart A22 – F Staff will also be re-in serviced on completing change in condition and incident reports.	7/10/09 7/2/09 7/10/09

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A22	Continued From page 6 information below it or a 05/28/09 entry. This additional entry revealed a staff member from the facility called regarding the fall and x-rays of the hips, knees and spine were requested but not of the left leg, hand or wrist.	A22	A 22 Cont. Two new reports will be developed to communicate information about each resident on each shift. One is a daily shift to shift log; the other is a body observation tool to be used when reporting skin condition changes. Staff will turn in to the Administrator for review and monitor.	7/10/09
A34	7 NMAC 8.2.34 Resident Rights 7.8.2.34 RESIDENT RIGHTS: All licensed facilities shall be aware of, protect, and enhance the rights of all residents. A. Prior to admission to a facility, a resident and/or legal representative shall be given a written description of the legal rights of the residents translated into another language, if necessary, to meet the residents understanding. B. If the resident is incapable of understanding his/her legal rights, and if he/she has no legal representative, then the licensee shall also give a written copy of the resident's legal rights to one of the following persons, in this order of priority: (1) the resident's spouse; (2) any of the resident's adult children; (3) either of the resident's parents; (4) any relative the resident has lived with for six or more months before admission; (5) a person who has been caring for, or paying benefits on behalf of the resident; (6) a placing agency; or (7) any other person, e.g., Ombudsman. C. These resident rights and the telephone number for the Ombudsman Program shall be posted in a conspicuous place in the facility: D. The facility, to protect resident rights must: (1) Treat all residents with courtesy, respect, dignity and compassion. (2) To the extent that resident required services fall within the scope of the facilities	A34		

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A34	Continued From page 7	A34		

program, avoid discrimination in admission or services because of a resident's age, race, religion, physical or mental disability, or nationality.

(3) Furnish residents written information about all services provided by the facility and their costs, and advance written notice of any changes.

(4) Assure that residents have a safe and sanitary living environment.

(5) Provide humane care.

(6) Assure the resident's rights to privacy in medical care, including privacy during medical examinations, consultations and treatment; and protect the confidentiality of the resident medical records.

(7) Protect and assure the resident's 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.

(8) Assure the resident's right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and assure the resident's right's to receive visits from family, friends, lawyers, ombudsmen and community organizations.

(9) Prohibit the use of any and all physical and chemical restraints.

(10) Assure the residents are free from physical and emotional abuse and neglect.

(11) Assure that all residents are free from financial abuse and exploitation by facility staff and/or management.

(12) Consistent with the resident's health, abilities and security, assure the right of the resident to freely participate in religious, social, community and other activities; and freely associate with persons in and out of the facility.

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A34	Continued From page 8 (13) Permit the residents to leave the facility freely and return without unreasonable restriction. (14) Prevent unjustified room transfers or discharge from this facility. (15) Use care and management practices that foster social interaction and avoid practices that unnecessarily result in social isolation. (16) Provide services consistent with informed consent. (17) Assure that all residents may voice grievances to the facility staff, public officials, the ombudsmen or any other person, without fear of reprisal or retaliation. (18) Promptly address and resolve resident complaints. (19) Foster resident participation and understanding in the development, review and modification of the resident's plan for care and treatment. (20) Respect a resident's choice of doctor, pharmacist and other health care provider. (21) Respect a resident's medical treatment decisions and advance directives, such as living wills and durable powers of attorney for health care. (22) Respect a resident's right to keep and use personal possessions without loss or damage. (23) Allow each resident to manage and control the resident's personal finances to the extent that the resident is able, and provide to every resident a written record of all financial arrangements and transactions involving that resident's funds. (24) Allow residents to freely organize and participate in a resident association that may recommend changes in the facility's policies,	A34		

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A34	Continued From page 9 services and management. (25) Require no resident to work for the facility. (26) Consult with the incapacitated resident regarding his/her care, regardless of the involvement of a guardian or surrogate decision maker. (27) Assure the involvement in, and consent of, an incapacitated resident's guardian or surrogate decision maker in the resident's care. E. The resident's rights shall not be restricted unless the resident agrees to such a restriction, and unless this restriction is described in detail in his/her individual service plan. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.34 NMAC - Rn, 7 NMAC 8.2.34, 8-31-00] This REQUIREMENT is not met as evidenced by: NMAC 7.8.2.34 D (5) Based on record review and interview, the facility failed to pass on reports to the Registered Nurse (RN) regarding possible complications from a fall, failed to request x-rays of the left leg, hand and wrist, and failed to monitor the resident's condition for signs and symptoms of injury for one of three (Resident #1) sampled residents. The findings are: A. Resident #1 was admitted to the facility on May 27, 2005 with diagnoses of hypertension and diabetes mellitus type II. B. Review of "Potential Change In Condition Notification" forms regarding a fall revealed the following: 1. On 05/24/09, a handwritten entry by Caregiver #2, "Getting [Resident #1] up from her bed. Had her walker in front of her, stood up did not hold on	A34	A 34 A - J Staff will be re-in serviced on completing change in condition and incident reports. When nurse does an assessment on a resident pertaining to a fall or skin condition report, he/she will respond in writing on the original report documenting the action taken and record same in the resident chart. The original completed report will be given to the Administrator for review and filing	7/10/09 7/10/09

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A34	Continued From page 10 to walker Let [sic] it go and held on to corner of small dresser. I held her fall felt [sic] against closet...She said she had weakness on left leg." 2. On 05/24/09, a handwritten entry by Caregiver #3, "It appears that [Resident #1]'s face is a little swollen. Mostly her right side of her face and her eyes." Under "Action taken," an entry by the Registered Nurse (RN), "Phy [Physician] called/assessed L knee therapist assessed able to do therapy c/ [with] her. Possible x-ray. No bruising or redness. Pain level 7 (scale 1-10)." 3. On 05/25/09, a handwritten entry by a Caregiver no longer employed, "On 05/24/09, [Resident #1] fell with staff and the 05/25/09 noticed [sic] left leg swollen and left hand and wrist swollen. and [sic] left wrist pain. When asked by staff she refused to go to hospital. Says she will see her own Doctor." C. Review of Nurses Notes for May 2009 and June 2009 revealed no entries or assessments of Resident #1's condition regarding a swollen face, left leg, left hand or left wrist. There were no assessments of the Resident's condition after the fall. D. Review of Physician's Orders revealed an order dated 05/28/09 requesting x-rays of the bilateral hips, knees and lower spine. There were no orders for an x-ray of the left leg, hand or wrist. E. Review of an x-ray report dated 05/29/09 revealed x-rays were taken of the right and left hip, lower spine and right knee. F. Review of an x-ray report for the left wrist dated 06/08/09 from the local hospital revealed, "There is an oblique fracture [a slanted fracture of the shaft along the bone's long axis] of the fourth	A34		

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A34	Continued From page 11 [ring finger]metacarpus [area between the wrist and finger] mid shaft without angulation. A fifth [little finger]metacarpal fracture without significant displacement may also be present." G. On 06/17/09 at 10:13 am, during an interview, the Assistant Administrator was asked why there were x-rays of the right side of the body and the hips when the injuries were to the left side of the body after a fall 05/24/09. She stated, "I don't know." She was asked where the documentation was of any assessment or response to the Change of Condition forms alleging swelling of the face and left leg, left hand and left wrist. She stated, "If she [the RN] assessed [Resident #1], it should be documented." When asked why the RN was documenting information about the left knee on the Change of Condition form alleging swelling of the face, she stated, "[The Administrator]'s going to have to look into this." H. On 06/17/09 at 2:30 pm, during an interview, the Administrator was asked about the reports of swelling to the face, left leg, left hand and left wrist. She stated she had never seen the Change of Condition reports alleging swelling. She could not provide an answer as to why the RN wrote about a swollen knee instead of responding to the report of a swollen face. The Administrator then stated that she had not noticed any swelling of the hand after the fall on 05/24/09 until she noted Resident #1's hand was swollen the day Resident #1 left for the hospital on 06/08/09. I. On 06/17/09 at 3:00 pm, during an interview, the RN joined in with the Administrator and reported she had not seen the Change of Condition reports regarding possible injury after the on 05/24/09 fall. When shown the form	A34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5772	A. BUILDING _____ B. WING _____	C 06/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADOBE ASSISTED LIVING #1 (THE)	1111 E MOUNTAIN LAS CRUCES, NM 88001

(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
A34	Continued From page 12 where she documented about the left knee instead of documenting about the swollen face, she reported, "I don't remember her having a swollen face." When shown the other report alleging swelling of the left leg, left hand and left wrist, the RN stated, "I almost always write something on these." The RN first stated she didn't see any swelling and then stated Resident #1 has swelling of the left hand because of a slight paralysis of the left side due to a cardiovascular accident. The RN reported she didn't think there were any issues with Resident #1 because the "Physical Therapist evaluated" Resident #1 and the "Administrator only told me about an issue with the left knee." When asked to show where she documented that, she admitted she had not. She admitted she never spoke with the Physician regarding the accident. "I think I called and left a message," she reported. Neither the Administrator nor the RN could explain why there were x-rays of the right knee, left and right hip and spine and not of the left arm, hand and knee. When asked where the RN's charting was of Resident #1's condition and the monitoring after the fall, the RN reported, "I should have charted it." She further admitted, "A lot of times I go to the recent Incident Reports and check on people but I don't chart it." The RN was asked if she should have been assessing Resident #1 and the Administrator answered for her, "Yes." J. On 06/18/09 at 7:00 am, during an interview, Caregiver #2 was asked to describe what happened during the fall on 05/24/09. She reported she was assisting Resident #1 out of bed when she let go of her walker and her left side "buckled." She reported she attempted to help break the fall but that Resident #1 fell on her left side and that her left wrist was "puffy" after	A34	A 34 Cont. Upon receiving incident reports, change in condition or Dr. orders the nurse will determine if the resident needs short or long term monitoring at that times. These reports will be kept in a binder titled, On Going Monitoring. Nurse will also at that time update the Assessment and the Service Plan for the resident. She will review these reports at least weekly. Upon completing that update the Administrator will review it and sign off on the Service Plan. Once the issue requiring additional monitoring is resolved, the nurse will document such information in the resident's chart and remove the report from the On Going Monitoring Book.	7/10/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5772	A. BUILDING _____ B. WING _____	C 06/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADOBE ASSISTED LIVING #1 (THE)	1111 E MOUNTAIN LAS CRUCES, NM 88001

(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
A34	Continued From page 13 the accident. She further stated that on 05/25/09, she noted Resident #1's wrist was swollen.	A34		