NEW MEXICO

7.9.2.2 SCOPE:

A. Services for residents shall be provided on a continuing twenty-four (24) hour basis and shall maintain or improve physical, mental and psychosocial well-being under plan of care developed by a physician or other licensed health professional and shall be reviewed and revised based on assessment.

B. All facilities licensed as nursing homes pursuant to Section 24-1-5 (A) NMSA 1978, are subject to all provisions of these regulations.

7.9.2.8 LICENSURE:

A. APPLICATION/REQUIREMENTS FOR LICENSURE:

...(2) In every application, the applicant shall provide the following information:

(a) The identities of all persons or business entities having the authority, directly or indirectly, to direct or cause the direction of the management or policies of the facility;

(b) The identities of all persons or business entities having five percent (5%) ownership interest whatsoever in the facility, whether direct or indirect, and whether the interest is in the profits, land or building, including owners of any business entity which owns any part of the land or building, and

(c) The identities of all creditors holding a security interest in the premises, whether land or building; and

(d) In the case of a change of ownership, disclosure of any relationship or connection between the old licensee and the new licensee, and between any owner or operator of the new licensee, whether direct or indirect.

7.9.2.11 SEPARATE LICENSES: Separate licenses shall be required for facilities which are maintained on separate premises even though they are under the same management. Separate licenses shall not be required for separate buildings on the same ground or adjacent ground.

7.9.2.13 POSTING: The license or a certified copy thereof shall be conspicuously posted in a location or accessible to public view within the facility.

7.9.2.14 REPORT OF CHANGES:

A. The licensee shall notify the department in writing of any changes in the information provided, within ten (10) days of such changes. This notification shall include information and documentation regarding such changes.

B. When a change of administrator occurs, the Department shall be notified within ten (10) days in writing by the licensee. Such writing shall include the name and license number of the new administrator.

C. Each licensee shall notify the Department within ten (10) days in writing of any change of the mailing address of the licensee. Such writing shall include the new mailing address of the licensee.
D. When a change in the principal officer of a corporate license (chairman, president, general manager) occurs the Department shall be notified within thirty (30) days in writing by the licensee. Such writing shall include the name and business address of such officer.
E. Any decrease, or increase in licensed bed capacity of the facility shall require notification by letter to the Department and shall result in the issuance of a corrected license.

7.9.2.20 PROGRAM FLEXIBILITY:

A. All facilities shall maintain compliance with the licensee requirements. If the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects conflicts with requirements, then prior written approval from the Department shall be obtained in order to ensure provisions for safe and adequate care. Such approval shall provide for the terms and conditions under which the exception is granted. A written request and substantiating evidence supporting the request shall be submitted by the applicant or licensee to the department.
B. Any approval of the Department granted under this section, or a certified copy thereof shall be posted immediately adjacent to the facility’s license.

7.9.2.26 ADMINISTRATOR/STATUTORY REFERENCE:

A nursing home shall be supervised by an administrator licensed under the Nursing Home Administrators Act, Sections 61-13-16 through 61-13-16 NMSA 1978. Supervision shall include, but not be limited to, taking all reasonable steps to provide qualified personnel to assure the health, safety, and rights of the residents.

A. FULL-TIME ADMINISTRATOR: Every nursing home shall be supervised full-time by an administrator licensed under the Nursing Home Administrators Act, except multiple facilities. If more than one nursing home or other licensed health care facility is located on the same or contiguous property, one full-time administrator may serve all the facilities.
B. ABSENCE OF ADMINISTRATOR: A person present in and competent to supervise the facility shall be designated to be in charge whenever there is not an administrator in the facility, and shall be identified to all staff.
C. CHANGE OF ADMINISTRATOR:
(1) Replacement of administrator: If it is necessary immediately to terminate an administrator, or if the licensee loses an administrator for other reasons, a replacement shall be employed or designated as soon as possible within one-hundred twenty (120) days of vacancy.
(2) Temporary replacement: During any vacancy in the position of administrator, the licensee shall employ or designate a person competent to fulfill the functions of an administrator immediately.
(3) Notice of change of administrator: When the licensee loses an administrator, the licensee shall notify the department within two (2) Department working days of such loss and provide written notification to the Department of the name and qualifications of the person in charge of the facility during the vacancy; and the name and qualifications of the replacement administrator, when known.

7.9.2.27 EMPLOYEES:

In this section, “employee” means anyone directly employed by the facility on other than a consulting or contractual basis.
A. QUALIFICATIONS AND RESTRICTIONS: No person under eighteen (18) years of age shall be employed to provide direct care to residents.

D. VOLUNTEERS: Facilities may use volunteers provided that the volunteers receive the orientation, training, and supervision necessary to assure resident health, safety and welfare.

E. ABUSE OF RESIDENTS:
(1) Orientation for all employees: Except in an emergency, before performing any duties, each new employee, including temporary help, shall receive appropriate orientation to the facility and its policies, including, but not limited to, policies relating to fire prevention, accident prevention, and emergency procedures. All employees shall be oriented to resident’s rights and to their position and duties by the time they have worked thirty (30) days.

(2) Training: Except for nurses, all employees who provide direct care to residents shall be trained through a program approved by the Department.

(3) Assignments: Employees shall be assigned only to resident care duties consistent with their training.

(4) Reporting: All employees will be instructed in the reporting requirements of the Adult Protective Services Act of abuse, neglect or exploitation of any resident.

F. CONTINUING EDUCATION:
(1) Nursing in-service: The facility shall require employees who provide direct care to residents to attend educational programs desired to develop and improve the skill and knowledge of the employees with respect to the needs of the facility’s residents, including rehabilitative therapy, oral health care, wheelchair safety and transportation and special programming for developmentally disabled residents if the facility admits developmentally disabled person. These programs shall be conducted quarterly to enable staff to acquire the skills and techniques necessary to implement the individual program plans for each resident under their care.

(2) Dietary in-service: Educational programs shall be held quarterly for dietary staff, and shall include instruction in the proper handling of food, personal hygiene and grooming, and nutrition and modified diet patterns served by the facility.

(3) All other staff in-service: The facility shall provide in-service designed to improve the skills and knowledge of all other employees.

7.9.2.28 RECORDS - GENERAL:

The administrator or administrator’s designee shall provide the Department with any information required to document compliance with these regulations and shall provide reasonable means for examining records and gathering the information.

7.9.2.29 PERSONNEL RECORDS: A separate record of each employee shall be maintained, be kept current, and contain sufficient information to support assignment to the employee’s current position and duties.

7.9.2.30 MEDICAL RECORDS - STAFF:
A. TIMELINESS: Duties relating to medical records shall be completed in a timely manner.
B. Each facility shall designate an employee of the facility as the person responsible for the medical record service, who:
(1) Is a graduate of a school of medical record science that is accredited jointly by the council on medical education of the American Medical Association; or
(2) Receives regular consultation but not less than four hours quarterly as appropriate from a person who meets the requirements of Section 30.2.1. Such consultation shall not be substituted for the routine duties of staff maintaining records. The records consultant shall evaluate the records and records service, identify problem areas, and submit written recommendations for change to the administrator.
(3) Sufficient time will be allocated to the person who is designated responsible for medical record service to insure that accurate records are maintained.

7.9.2.31 MEDICAL RECORDS - GENERAL:
A. AVAILABILITY OF RECORDS: Medical records of current residents shall be stored in the facility and shall be easily accessible, at all times, to persons authorized by the resident to obtain the release of the medical records.
B. ORGANIZATION: The facility shall maintain a systematically organized records system appropriate to the nature and size of the facility for the collection and release of resident information.
C. UNIT RECORD: A unit record shall be maintained for each resident and day care client.
D. INDEXES: A master resident index shall be maintained.
E. MAINTENANCE: The facility shall safeguard medical records against loss, destruction, or unauthorized use, and shall provide adequate space and equipment to efficiently review, index, file and promptly retrieve the medical records.
F. RETENTION AND DESTRUCTION:
(1) The medical record shall be completed and stored within sixty (60) days following a resident’s discharge or death.
(2) An original medical record and legible copy or copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of this resident shall be retained for a period of at least ten (10) years following a resident's discharge or death. All other records required by these regulations shall be retained for the period for which the facility is under review.
(3) Medical records no longer required to be retained under this section may be destroyed, provided:
   (a) The confidentiality of the information is maintained; and
   (b) The facility permanently retains at least identification of the resident, final diagnosis, physician, and dates of admission and discharge.
(4) A facility shall arrange for the storage and safekeeping of records for the periods and under the conditions required by this paragraph in the event the facility closes.
(5) If the ownership of a facility changes, the medical records and indexes shall remain with the facility.
G. RECORDS DOCUMENTATION:
(1) All entries in medical records shall be legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.
(2) Symbols and abbreviations may be used in medical records if approved by a written facility policy which defines the symbols and abbreviations and which controls their use.

7.9.2.32 MEDICAL RECORDS - CONTENT: Except for persons admitted for short-term care, each resident’s medical record shall contain:
A. IDENTIFICATION AND SUMMARY SHEET:

B. PHYSICIAN’S DOCUMENTATION:
(1) An admission medical evaluation by a physician, including:
(a) A summary of prior treatment;
(b) Current medical findings;
(c) Diagnosis at the time of admission to the facility;
(d) The resident’s rehabilitation potential;
(e) The results of the required physical examination;
(f) Level of care;
(2) All physician’s orders including:
(a) Admission to the facility;
(b) Medications and treatments;
(c) Diets;
(d) Rehabilitative services;
(e) Limitations on activities;
(f) Restraint orders;
(g) Discharge or transfer orders.
(3) Physician progress notes following each visit.
(4) Annual physical examination.
(5) Alternate visit schedule, and justification for such alternate visits, not to exceed ninety (90) days.

C. NURSING SERVICE DOCUMENTATION:
(1) An assessment of the resident’s nursing needs.
(2) Initial nursing care plan and any revisions.
(3) Nursing notes are required as follows:
(a) For residents requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident’s condition, but at least weekly; and
(b) For residents not requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident’s condition, but at least monthly;
(4) In addition to the nursing care plan, nursing documentation describing:
(a) The general physical and mental condition of the resident, including any unusual symptoms or actions;
(b) All incidents or accidents including time, place, injuries or potential complications from injury or accident, details of incident or accident, action taken, and follow-up care;
(c) The administration of all medications, the need for PRN medications and the resident’s response, refusal to take medication, omission of medications, errors in the administration of medications, and drug reactions;
(d) Food intake, when the monitoring of intake is necessary;
(e) Fluid Intake when monitoring of intake is necessary;
(f) Any unusual occurrences of appetite or refusal or reluctance to accept diets;
(g) Summary of restorative nursing measures which are provided;
(h) Summary of the use of physical and chemical restraints;
(i) Other non-routine nursing care given;
(j) The condition of a resident upon discharge; and
(k) The time of death, the physician called, and the person to whom the body was released.

D. SOCIAL SERVICES RECORDS:
A social history of the resident; and
(2) Notes regarding pertinent social data and action taken.

E. ACTIVITIES RECORDS: Documentation of activities programming, a history and assessment, a summary of attendance, and quarterly progress notes.

F. REHABILITATIVE SERVICES:
(1) An evaluation of the rehabilitative needs of the resident.
(2) Plan of treatment.
(3) Progress notes detailing treatment given, evaluation, and progress.

G. DIETARY ASSESSMENT: Record of the dietary assessment.

H. DENTAL SERVICES: Summary of all dental services resident has received.

I. DIAGNOSTIC SERVICES: Records of all diagnostic tests performed during the resident’s stay in the facility.

J. PLAN OF CARE: Plan of care which includes integrated program activities, therapies and treatments designed to help each resident achieve specific goals as developed by an interdisciplinary team.

K. AUTHORIZATION OR CONSENT: A photocopy of any court order, power of attorney or living will authorizing another person to speak or act on behalf of the resident and any resident consent forms.

L. DISCHARGE OR TRANSFER INFORMATION: Documents, prepared upon a resident’s discharge or transfer from the facility, summarizing, when appropriate:
(1) Current medical finding and condition;
(2) Final diagnosis;
(3) Rehabilitation potential;
(4) A summary of the course of treatment;
(5) Nursing and dietary information;
(6) Ambulation status;
(7) Administrative and social information; and
(8) Needed continued care and instructions.

7.9.2.33 OTHER RECORDS: The facility shall retain:

A. DIETARY RECORDS: All menus and therapeutic diets for one year.

B. STAFFING RECORDS: Records of staff work schedules and time worked for one year.

C. SAFETY TESTS: Records of tests of fire detection, alarm, and extinguishment equipment.

D. RESIDENT CENSUS: At least a daily census of all residents, indicating number of residents requiring each level of care.

E. PROFESSIONAL CONSULTATIONS: Documentation of professional consultations by:
(1) A dietician.
(2) A registered nurse.
(3) Others, as may be used by the facility.

F. IN-SERVICE AND ORIENTATION PROGRAMS: Subject matter, instructors and attendance records of all in-service and orientation programs.

G. TRANSFER AGREEMENTS: Transfer agreements.

H. FUNDS AND PROPERTY STATEMENT: The statement prepared upon a resident’s discharge or transfer from the facility that accounts for all funds and receipted property held by the facility for the resident.

I. COURT ORDERS AND CONSENT FORMS: Copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of the resident.
7.9.2.39 TRANSFER AGREEMENTS:

A. REQUIREMENT: Each facility shall have in effect a transfer agreement with one or more hospitals under which in-patient hospital care or other hospital services are available promptly to the facility’s resident’s when needed. Facilities under same management having identified distinct parts are exempt from transfer agreements.

B. TRANSFER OF RESIDENTS: A hospital and a facility shall be considered to have a transfer agreement in effect if there is a written agreement between them or, when the two (2) Institutions are under common control, if there is a written statement by the person or body which controls them, which gives reasonable assurance that:

(1) Transfer of residents will take place between the hospital and the facility ensuring timely admission, whenever such transfer is medically appropriate as determined by the attending physician; and

(2) There shall be interchange of medical and other information necessary for the care and treatment of individuals transferred between the institutions or for determining, whether such individuals can be adequately cared for somewhere other than in either of the institutions.

C. EXEMPTION: A facility which does not have a resident transfer agreement in effect, but which is found by the Department to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between the two facilities and the information referred to in Subsection (B) of 7.9.2.39 NMAC above, shall be considered to have such an agreement in effect if and for so long as the department finds that to do so is in the public interest and essential to ensuring nursing facility services in the community.

7.9.2.45 PHYSICAL AND CHEMICAL RESTRAINTS:

„G. RECORDS: Any use of restraints shall be noted, dated, and documented in the resident’s clinical record on each tour of duty during which the restraints are in use.

7.9.2.48 MEDICAL DIRECTION IN SKILLED CARE FACILITIES:

A. MEDICAL DIRECTOR: Every skilled care facility shall retain, pursuant to a written agreement, a physician to serve as medical director on a part-time or full-time basis as is appropriate for the needs of the residents and the facility. If the facility has an organized medical staff, the medical director shall be designated by the medical staff with approval of the licensee.

B. COORDINATION OF MEDICAL CARE: Medical direction and coordination of medical care in the facility shall be provided by the medical director. The medical director shall be responsible for development of written rules and regulations which shall be approved by the licensee and include delineation of the responsibilities of attending physicians. If there is an organized medical staff, by-laws also shall be developed by the medical director and approved by the licensee. Coordination of medical care shall include liaison with attending physician to provide that physicians’ orders are written promptly upon admission of a resident, that periodic evaluations of the adequacy and appropriateness of health professional and supportive staff and services are conducted, and that the medical needs of the residents are met.
C. RESPONSIBILITIES TO THE FACILITY: The medical director shall monitor the health status of the facility's employees. Incidents and accidents that occur on the premises shall be reviewed by the medical director to identify hazards to health and safety.

7.9.2.50 NURSING SERVICES:

B. DIRECTOR OF NURSING SERVICES IN SKILLED CARE AND INTERMEDIATE CARE FACILITIES:
(1) Staffing requirement: Every skilled care facility and every intermediate care facility shall employ a full-time director of nursing services who may also serve as a charge nurse. The director of nursing services shall work only on the day shift except as in an emergency or required for the proper supervision of nursing personnel.
(2) Qualifications: The director of nursing services shall:
(a) Be a registered or licensed practical nurse...

7.9.2.58 DIAGNOSTIC SERVICES:

A. REQUIREMENT OF SERVICES: The facility shall provide for promptly obtaining required laboratory, x-ray, and other diagnostic services.
B. FACILITY-PROVIDED SERVICES: Any laboratory and x-ray services provided by the facility shall meet the applicable requirements for hospitals.
C. OUTSIDE SERVICES: If the facility does not provide these services, arrangements shall be made for obtaining the services from a physician's office, hospital, nursing facility, portable x-ray supplier, or independent laboratory.
D. PHYSICIAN’S ORDER: No services under the subsection may be provided without an order of a physician.
E. NOTICE OF FINDINGS: The attending physician shall be notified promptly of the findings of all tests provided under this subsection.
F. TRANSPORTATION: The facility shall assist the resident, if necessary, in arranging for transportation to and from the provider of service.
(1) Any employee or agent of a regulated facility or agency who is responsible for assisting a resident in boarding or alighting from a motor vehicle must complete a state-approved training program in passenger transportation assistance before assisting any resident. The passenger transportation assistance program shall be comprised of but not limited to the following elements: resident assessment, emergency procedures, supervised practice in the safe operation of equipment, familiarity with state regulations governing the transportation of persons with disabilities, and a method for determining and documenting successful completion of the course. The course requirements above are examples and may be modified as needed.
(2) Any employee or agent of a regulated facility or agency who drives a motor vehicle provided by the facility or agency for use in the transportation of clients must complete:
(a) A state approved training program in passenger assistance and
(b) A state approved training program in the operation of a motor vehicle to transport clients of a regulated facility or agency. The motor vehicle transportation assistance program shall be comprised of but not limited to the following elements: resident assessment, emergency procedures, supervised practice in the safe operation of motor vehicles, familiarity with state regulations governing the transportation of persons with
disabilities, maintenance and safety record keeping, training on hazardous driving conditions and a method for determining and documenting successful completion of the course. The course requirements above are examples and may be modified as needed.
(c) A valid New Mexico drivers license for the type of vehicle being operated consistent with State of New Mexico requirements.
(3) Each regulated facility and agency shall establish and enforce written polices (including training) and procedures for employees who provide assistance to clients with boarding or alighting from motor vehicles.
(4) Each regulated facility and agency shall establish and enforce written polices (including training and procedures for employees who operate motor vehicles to transport clients.

7.9.2.61 SOCIAL SERVICES:
...(4) Training: Participation in in-service training for direct care staff on the emotional and social problems and needs of the aged and ill and on methods for fulfilling these needs.

7.9.2.71 PHYSICAL ENVIRONMENT:
...
G. RESIDENT SAFETY AND DISASTER PLAN:
(1) Disaster Plan:
(a) Each facility shall have a written procedure which shall be followed in case of fire or other disasters, and which shall specify persons to be notified, locations of alarm signals and fire extinguishers, evacuation routes, procedures for evacuating helpless residents, frequency of fire drills and assignment of specific tasks and responsibilities to the personnel of each shift and each discipline.
(b) The plan developed by the facility shall be submitted to qualified fire and safety experts, including the local fire authority, for review and approval. The facility shall maintain documentation of approval by the reviewing authority.
(c) All employees shall be oriented to this plan and trained to perform assigned tasks.
(d) The plan shall be available at each nursing station.
(e) The plans shall include a diagram of the immediate floor area showing the exits, fire alarm stations, evacuation routes and location of fire extinguishers. The diagram shall be posted in conspicuous locations in the corridor throughout the facility.
(2) Drills: Fire drills shall be held at irregular intervals at least four (4) times a year on each shift and the plan shall be reviewed and modified as necessary. Records of drills and dates of drills shall be maintained.
...(5) Fire Report: All incidents of fire in a facility shall be reported to the department within seventy-two (72) hours.