Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7117	A. BUILDING: _____ B. WING _____	C 10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA ALBUQUERQUE	1620 INDIAN SCHOOL ROAD NE ALBUQUERQUE, NM 87102

(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 Complaint survey completed on [redacted]/23 for the state requirements of NMAC 7.8.2, Regulations for Assisted Living Facilities for Adults. Complaint Intake ID [redacted] was investigated with deficiencies cited. Complaint Intake ID [redacted] was investigated with deficiencies cited. Complaint Intake ID [redacted] was investigated with no deficiencies cited. Complaint Intake ID [redacted] was investigated with no deficiencies cited. Census: 140	A 000		
A 019	7 NMAC 8.2.19 Staffing Ratios STAFFING RATIOS: The following staffing levels are the minimum requirements. A. The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents ' needs. (1) During resident waking hours, facilities shall have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents. (2) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty, awake and responsible for the care and supervision of the residents. (3) During resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises.	A 019	A 019 7 NMAC 8.219 Staffing Ratios 1.Facility Administrator will ensure that the staffing ratio requirement of at least 1 direct care staff member on duty per every 15 residents will be followed. 2.Health and Wellness director will ensure ongoing complaince is met by reviewing weekly schedules. 3.Facility eliminated the use of staffing agencies on [redacted]2022. 4.Facility Administrator will monitor that all call pendants will be responded to within 15 minutes or less of the pendant being pressed by running and reviewing daily pendant log. 5.A re-training on pendant response times was completed by Health & Wellness director on [redacted]/2023.	[redacted]2023

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mona Rucker TITLE: Executive Director. (X6) DATE: 1/10/2024

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A 019	Continued From page 1 (4) During resident sleeping hours, facilities with thirty-one (31) to sixty (60) residents shall have at least two (2) direct care staff persons on duty and awake at all times and at least one (1) additional staff person immediately available on the premises. (5) During resident sleeping hours, facilities with more than sixty-one (61) residents shall have at least three (3) direct care staff persons on duty and awake at all times and one (1) additional staff person immediately available on the premises for each additional thirty (30) residents or fraction thereof in the facility. B. Upon request of the department, the facility shall provide the staffing ratios per each twenty-four (24) hour day for the past thirty (30) days. [7.8.2.19 NMAC - Rp, 7.8.2.18 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: This is a repeat deficiency from survey dated [redacted]/22. 7.8.2.19 A (1, 5) Based on record review and interview, the facility failed to ensure there was enough Direct Care Staff (DCS) on duty at all times to provide the basic care, resident assistance, and the required supervision based on the assessment of the residents' needs. This deficient practice could likely result in the [redacted] residents identified on the Assisted Living (AL) resident census provided by the Executive Director on [redacted]23, to be at risk of harm, injury if there are not adequate staffing	A 019		

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A 019	Continued From page 2 available to assist residents. The findings are: A. Record review of Complaint Intake [redacted] received on [redacted]22, the Complainant stated that on [redacted]/22, R #3 was not checked on by the DCS in over 36 hours. B. On [redacted]23 at 1:35 pm, during an interview, the Complainant confirmed: 1. R #3 had a Private Duty Caregiver that was not working on [redacted]22, the date of the incident. The Complainant notified the facility and they (DCS) were supposed to assist the resident when needed. 2. The facility DCS put R #3 to bed on [redacted]/22 (unknown time) and when the Private Caregiver returned to the facility on [redacted]22 (unknown time), she found R #3 still in bed soiled (feces and urine present in [redacted]ndergarments), and R #3 reported that DCS did not get [redacted]up. R #3 had pushed [redacted] pendant, the DCS never came, and they (DCS) ignored [redacted]r more than 24 hours. 3. The Complainant voiced his opinion to (unknown staff) but the facility swept it under the carpet, apologized, and said they (facility) would take care of it. C. On [redacted]/23 at 11:40 am, during an interview, DCS #8 who was scheduled to work on [redacted]/22, stated that she remembers hearing about the incident and being talked to about a resident not being checked on, but could not remember the details. D. On [redacted]23 at 12:12 pm, during an interview, DCS #9 who was scheduled to work on [redacted]/22, stated the following:	A 019		

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A 019	Continued From page 3 1. R #3 had a Private Duty Caregiver and does not remember if the resident was checked on, on the date of the incident. 2. When residents have a Private Duty Caregiver, they are usually notified if the Private Duty Caregiver will not be at the facility, so they can do checks on the resident. 3. She (DCS #9) does not remember if they were told that R #3's Private Duty Caregiver was not going to be at the facility on the date of the incident. Findings related to staffing: F. Record review of the Facility AL Census for [redacted]/22, revealed there were 104 residents which would require: 1. Seven (7) DCS on duty and awake at all times during resident waking hours. 2. Three (3) DCS on duty and awake at all times and two (2) DCS immediately available on the premises during sleeping hours for a total of five (5) DCS. F. Record review of the Staff Timecards for [redacted]22 for the Assisted Living part of the facility revealed: 1. There were no DCS scheduled to be on shift from 12:00 am to 6:58 am 2. One (1) DCS was scheduled to be on shift from 6:58 am to 2:51 pm 3. Two (2) DCS were scheduled to be on shift from 2:51 pm to 4:09 pm 4. One (1) DCS was scheduled to be on shift from 4:09 pm to 10:58 pm 5. There were no DCS scheduled to be on shift from 10:58 pm to 11:59 pm G. On [redacted]23 at 2:18 pm, during an interview, the Executive Director (ED) confirmed:	A 019		

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A 019	Continued From page 4 1. The timecards that were provided showed low staffing on [redacted]22 and there was not a DCS from 10:58 pm to 11:59 pm and again from 12:00 am to 6:58 am. 2. ED was not hired at the facility until [redacted]/22 and was not aware of the staffing issues but could confirm that the facility was using a contracted staffing agency at that time. 3. There were no timecards or facility records to show when the staffing agency DCS were working, because the previous ED did not save them H. On [redacted]23 at 11:40 am, during an interview, DCS #8 confirmed staffing around [redacted]/22 was low on some days and especially on the weekends. I. On [redacted]23 at 12:12 pm, during an interview, DCS #9 confirmed that during the time of [redacted]/22, the facility was working with a "skeleton" (The bare minimum amount of employees) crew of one to two DCS per shift and two additional from the staffing agency.	A 019		
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;	A 021	A 021 7 NMAC 8.2.21 Resident Records 1. Facility Administrator will ensure that all residents records are kept for 5 years after discharge and be readily available within 24 hours if requested. 2. Facility Administrator will ensure that all current residents' documents are being stored and maintained properly following all HIPPA guidelines. 3. Health and Wellness Director will monitor compliance by doing monthly chart audits to all residents' charts and files.	[redacted]2023

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A 021	Continued From page 5 (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (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,	A 021		

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A 021	Continued From page 6 in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible	A 021		

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A 021	Continued From page 7 and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.21 B (3) Based on record review and interview, the facility failed to ensure for [redacted] former resident that non-current resident records were 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. If the former resident records are not maintained and readily available, then vital information regarding the resident while at the facility will not be available when making current health, safety, and welfare decisions. If the resident, family, health care providers, and licensing authority do not have access to the former resident's facility	A 021		

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A 021	Continued From page 8 records then the resident is at risk of harm if incorrect health, safety, and welfare decisions are made because the vital information is not available. The findings are: The findings are: A. Record request made on [redacted]23 at 10:20 am for R #3's (admission date: [redacted] resident file revealed, the facility did not have any documentation (including evaluations and/or Individual Service Plans (POCs) for the resident from [redacted]20 up till the date of discharge on [redacted] B. On [redacted]23 at 2:18 pm, during an interview, the Executive Director (ED) confirmed the resident records was not available to review for R #3 due to the prior ED not saving any resident records for R #3.	A 021		
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 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 026	A 026 7 NMAC 8.2.26 Individual Service Plan 1.Assessment and ISP will be completed upon admission by Director of Health and Wellness. After resident has physically moved into facility Director of Health and wellness will have a meeting with residents POA to review ISP and assessment. 2.The assessment will be re-evaluated every six months or upon change due to residents needs and a new ISP will be created. 3.Each ISP will be reviewed and signed off on by a licensed practical nurse, registered nurse, or a physician extender. 4.Facility Administrator will audit charts quarterly to ensure that compliance being met and in a timely manor.	[redacted]2023

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A 026	Continued From page 9 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: This is a repeat deficiency from survey dated [redacted]/22. 7.8.2.26 A (2-3) Based on record review and interview, the facility failed to ensure for [redacted] former resident whose resident file was reviewed for compliance, that an ISP was: 1. Developed within ten (10) calendar days of admission.	A 026		

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A 026	Continued From page 10 2. Reviewed and updated at a minimum of every 6 month by a Licensed Practical Nurse (LPN), Registered Nurse (RN) or Physician Extender (PE). These deficient practices could likely cause the residents to suffer harm and neglect, if the Direct Care Staff (DCS) did not know what care/services to provide, because an ISPs was never created, reviewed, and/or updated as required by regulation, The findings are: A. Record review of R #3's (admission date: [redacted] resident file revealed no documentation that an ISP was: 1. Completed within ten (10) calendar days of admission. 2. Reviewed and updated at a minimum of every 6 months. B. On [redacted]/23 at 2:18 pm, during an interview, the Executive Director stated she could not confirm if an ISP was completed for R #3, because no records for R #3 (former resident) have been located except for a facesheet. C. On [redacted]23 at 12:12 pm, during an interview, Direct Care Staff (DCS) #9 confirmed R #3 did not have an ISP in the record and she (DCS #9) was not aware of what care and services R #3 needed assistance with.	A 026		
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The	A 038	A 036 7 NMAC 8.2.38 Housekeeping Services 1.Facility Maintenance Director will ensure that all residents' apartments whom have pets will receive carpet cleaning monthly. 2.Record of carpet cleaning will be kept in residents' personal file.	[redacted]/2024

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A 038	Continued From page 11 facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.38 A Based on observation and interview, the facility failed to ensure the resident bedrooms were kept clean and sanitary. This deficient practice could likely result in the [redacted]esidents listed on the census provided by the Executive Director (ED) on [redacted]23, to be at risk of harm, injury, or death if residents were exposed to bacteria, germs, or feces. The findings are: A. On [redacted]23 at 11:10 am, during observation	A 038	3. Facility Administrator will ensure compliance is being met by doing monthly walk throughs of residents' apartments whom have pets.	

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A 038	Continued From page 12 of R #10's [redacted] extremely strong pet odors (urine and feces) were smelled at the exterior of the door. Upon entering the room the scents of pet dander (a collection of skin cells, hair, and other things that pet bodies shed) and stale pet urine odors were noted. B. On [redacted]23 at 11:25 am, during observation of R #9's [redacted] evealed, an extremely strong pet odors (urine and feces) were smelled at the exterior door. The smell intensified upon entering the room and the carpet in the rooms showed signs of multiple pet urine stains C. On [redacted]/23 at 2:23 pm, during an interview, the Executive Director confirmed strong pet odors were present in both rooms. D. On [redacted]/23 at 12:42 pm, during an interview, R #13 confirmed [redacted] able to smell the strong pet scents (dander, feces, urine) from the hallway when walking by R #10's [redacted]	A 038		
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards.	A 042	A 042 7 NMAC 8.2.42 Maintenance of Building and Grounds. 1.Facilities Director of Maintenance will ensure that all pendants and the pendant system are operational by running "Daily Pendant Report". Facility Administrator will ensure compliance is met by reviewing report daily. Any issues with pendants will be reported to the residents who are being affected. 2.In the event that the pendant system does go down the direct care staff will do 30 minute walk-through checks on all residents who are affected until the issue is resolved. 3.Record of these checks will be kept in Health and Wellness Director's office in a binder labeled "Fire Watch/Pendant System Down Checks".	[redacted]2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7117	A. BUILDING: _____ B. WING _____	C 10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 042	Continued From page 13 [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.42 Based on record review and interview, the facility failed to ensure the facility's emergency call lights were functioning properly. These deficient practices could likely result in harm to the [redacted]esidents identified on the Assisted Living (AL) resident census provided by the Executive Director on [redacted]/23, to be at risk of harm if they do not receive care and assistance when needed because the DCS are not alerted or know when the residents are calling for help. The findings are: A. Record review of Complaint Intake [redacted] received on [redacted]/22, revealed the Complainant stated that o[redacted]22, R #3 was not checked on by the DCS in over 36 hours and did not receive [redacted] meals because the facility's pendant system (used by residents to call for assistance) was broken and no one responded to [redacted] pendant calls. B. Or[redacted]23 at 1:35 pm, during an interview, the Complainant confirmed: 1. He was told (by unknown staff) that the pendant system was down and that the pendants had not been working all week. 2. The facility never advised any of the residents that the pendants were not working. C. Record review of the facility's pendant reports dated [redacted]22 through [redacted]22, revealed there	A 042		

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A 042	Continued From page 14 were no reported pendant calls between: 1. [redacted]22 at 8:25 pm and [redacted]/22 at 10:51 am, 2. [redacted]/22 at 11:20 pm and [redacted]/22 at 10:05 am. D. On [redacted]23 at 2:18 pm, during an interview, the Executive Director confirmed there were no recorded pendant calls between [redacted]/22 at 8:25 pm and [redacted]22 at 10:51 am, and again between [redacted]/22 at 11:20 pm and [redacted]/22 at 10:05 am. The Executive Director stated she was not aware if the pendant system was broken or not, because she was not working at the facility at the time. E. On [redacted]23 at 11:40 am, during an interview, Direct Care Staff (DCS) #8 confirmed there were multiple occasions when the pendant call system was down, and the facility had protocols to follow when that occurred including conducting one and two hour checks on residents. F. On [redacted]/23 at 12:12 pm, during an interview with DCS #9 confirmed there were multiple times the pendant system went down.	A 042		