Gmail

Alamogordo Aristocrat <director.alaaristocrat@gmail.com>

POC Corrections Needed

1 message

Gallegos, Santiago, DOH <SantiagoF.Gallegos@doh.nm.gov> Thu, Feb 23, 2023 at 3:13 PM
To: "director.alaaristocrat@gmail.com" <director.alaaristocrat@gmail.com>
Cc: "Curlee, Alana, DOH" <Alana.Curlee@doh.nm.gov>

Good afternoon,

The Plan of Correction (POC) for Survey Event ID #2H2P11, License #5729 has been reviewed and the following corrections are needed:

A016- What process will be put in place to ensure ongoing compliance for new staff?

A017- Take out name (Teresa). Only include position titles no names. What process will be put in place to ensure ongoing compliance for new staff?

A034- Please describe what will be done in the monthly checks by DON.

A038 - What process will be put in place to ensure ongoing compliance for new staff? how and who will monitor?

Once you receive this notification, please call/email me if you have any questions or need assistance.

Thank you

emailed 02/24/23 7:17 am M. Armstrong

Santiago Gallegos
Licensed-Only Surveyor

NMDOH
NEW MEXICO DEPARTMENT OF HEALTH

Licensed Oversight Department
Department of Health/District Operations Bureau

5300 Homestead Road NE

Albuquerque, New Mexico 87110
Cell:(505) 795-2114
Fax:(505) 841-6551

santiagof.gallegos@doh.nm.gov

Accredited since 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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/Complaint survey conducted on 10/27/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living for Adults. Complaint Intake #NM55827 was unsubstantiated with no deficiencies cited.	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC.	A 016	Don will interview and ensure compliance with the Regulations HR will do all the paperwork in compliance with DOH. Director will check all employees Files and ensure compliance This will be ongoing 1/1/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 016	Continued From page 1 B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010]	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 016	Continued From page 2 This REQUIREMENT is not met as evidenced by: Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information	A 016	ALL employees will have 12/20/22 Clearance by DOH. Ongoing monitoring by Director to check all new employee charts	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 016	Continued From page 3 concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 016	Continued From page 4 contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: A. General: The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers, and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers, or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978 (Amended) of the act, a care provider's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider] to impose appropriate administrative sanctions and penalties. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver, or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 016	Continued From page 5 employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. 7.8.2.16. B (3) (7) Based on record review and interview, the facility failed to ensure for that the Direct Care Staff(DCS): 1. Received clearances from the Employee Abuse Registry (EAR) prior to hire. 2. Had their applications and fingerprints for the Caregiver Criminal History Screening Program (CCHSP) submitted within 20 days of hire. This deficient practice could likely have a negative affect on the safety and welfare of the 39 (R #s 1-39) residents identified on the census provided by the Acting Administrator on 10/24/22, if residents are being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents and who may have a previous criminal history. The findings are: A. Record review of DCS #1s employee file (hire date 02/18/14) revealed: 1. The EAR clearance was not documented as completed until 03/13/14. 2. The application and fingerprints were not submitted to the CCHSP until 03/18/14.	A 016	1/1/23 ongoing ALL employees are Cleared and fingerprints are done within 20 Days of hire. Director to monitor Compliance. Human Resourses and DON will ALSO Monitor ALL new employees. Human Resourses Don-Hires HR- new employee paper-work Director - monitor employee Files for Compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 016	Continued From page 6 B. Record review of DCS #2s employee file (hire date 05/20/21) revealed: 1. The EAR clearance was not documented as completed until 12/27/21. 2. The application and fingerprints were not submitted until 12/27/21. C. Record review of DCS#3s employee file (hire date 08/04/22) revealed, no documentation that the EAR was completed. D. Record review of DCS #4s employee file (hire date 02/16/22) revealed, that the EAR/CCHSP clearance was not completed until 03/15/22. E. On 10/27/22 at 11:17 am, during an interview with the Acting Administrator, she confirmed that the previous Administrators failed to complete the EAR and CCHSP clearances for DCS #s 1-4 timely.	A 016	1/1/23 Human Resources assigns Relias Courses to all employees and monitors compliance with Completion of courses. New employees 16 hrs training signed by trainor. Fire safety, safe food handling also done. Including Relias Courses	
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 017	1/1/23 ALL newly hired employees ongoing complete 16 hours of training Relias training is used For annual classes Fire drills done monthly Any Caregiver must complete the medication class and pass the test and also do training in medication pass, Director & ~~Supervisor~~ to monitor ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 017	Continued From page 7 (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; (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 A B C (1 - 12) Based on record review and interview, the facility failed to ensure that all (DCS) Direct Care Staff received the training required by regulation listed below and that documentation of the completed trainings were onsite at the facility and available for review: 1. 16 hours supervised training prior to providing unsupervised care for residents.	A 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 017	Continued From page 8 2. Medication Assistance training or Certification for assisting residents with medication. 3. Orientation and subsequent training that included any of the required 12 hours of yearly training that may include: fire safety, first aid, resident information confidentiality, infection control, personal hygiene, confidentiality, resident rights, reporting abuse neglect or exploitation in accordance with 7.1.13 NMAC, methods to provide quality resident care, emergency procedures, proper implementation of ISP (Individual Service Plan). These deficient practices could likely result in the 38 (R #s 1-38) residents listed on the resident census, provided by the Administrator on 10/24/2022, to be at risk of harm if they are receiving care and services by DCS who have not received the required trainings. The findings are: A. Record review of DCS #3s employee file (hire date 08/04/22), revealed no documentation of completion of the following training requirements with proof of competency: 1. 16 hours supervised training prior to providing unsupervised care for residents. 2. Medication Assistance training. 3. Orientation and subsequent training that included any of the required 12 hours of yearly training. B. Record review of DCS #4s employee file (hire date 02/16/22), revealed no documentation of completion of the following training requirements with proof of competency: 1. 16 hours supervised training prior to providing unsupervised care for residents. 2. Medication Assistance training. 3. Orientation and subsequent training that included any of the required 12 hours of yearly	A 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 017	Continued From page 9 training. C. On 10/25/22 at 2:28 pm during an interview with the Acting Administrator she confirmed that the previous Administrator failed to ensure that DCS #s 3 and 4 completed and had documentation of completion of following required trainings: 1. 16 hours supervised training prior to providing unsupervised care for residents. 2. Medication Assistance training. 3. The required 12 hours of orientation and/or annual trainings.	A 017		
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 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.	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 034	Continued From page 10 (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; (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	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 034	Continued From page 11 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. (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: 7.8.2.34 A (5) B (1)	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 034	Continued From page 12 Based on record review, observation, and interview, the facility failed to ensure for 1 (R #3) of 1 (R#3) who stores medications in his resident room and self-administers medications, that all medications observed in the residents room in the facility were: 1. Ordered by the residents physician. 2. Documented on the residents Medication Administration Records (MAR) at the facility. 3. Started and stopped with specific orders from the residents physician. 4. Reviewed by the Consulting pharmacist and records maintained by the facility. These deficient practices could likely cause harm to the resident if: 1. There were medications available in the residents room, and being taken by the resident without a physician's orders. 2. The facility had no documentation on the residents MAR of all medications available and being self-administered by the resident. 3. The resident was not following the physicians orders when taking medications. 4. All medications stored by R#3s room were not observed to be stored in a locked compartment. 5. The residents medication administration regime and medication storage was not reviewed and documented by the Consulting Pharmacist with records available in the facility for review. The findings are: A. On 10/27/2022 at 1:52 pm, during observation of the medications stored in R #3s residents room #8 for self-administration the following was observed in R#3s room: 1. The resident was prescribed [redacted]	A 034	ongoing 11/1/23 The Director of Nursing has obtained orders for all Self-Administer Medications, All Residents have a Lock box. She also does monthly checks of ALL Residents that self prescribe (Administer) A Letter Addressing Refusal of Medication assistance and monthly Medication checks Done by DON. DON TO make sure all Medications are correct dosage and have Orders for them, and they are all on the MAR	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 034	Continued From page 13 instead the resident had [redacted] 2. The resident was prescribed [redacted] Supplement tablets 1 tablet by mouth daily, and no [redacted] was available. 3. The following medications and supplements were observed in R #3s room, but were not found on R#3s current MAR or Physicians orders: [redacted] 4. R #3s medications were observed to be stored in an unlocked metal box and in a brown paper bag in [redacted] room. 5. Record review and interview on 10/24/2022 with Acting Administrator revealed that the facility/pharmacist were not monitoring the medications stored in R#3s room. B. On 10/27/22 at 2:15 pm, during an interview with the DCS #2 the facility (LPN) Licensed Practical Nurse, she confirmed: 1. The bottle of 81 mg Aspirin observed in the residents room for self administration was not the correct of [redacted] dosage as prescribed and listed on the residents MAR. 2. The resident did not have the prescribed [redacted] daily available for self administration as prescribed and listed on the residents MAR. 3. For the following medications and supplements observed in R #3s room that there were no physicians orders available at the facility: [redacted]	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 034	Continued From page 14 day supply. 4. The facility/pharmacist were not monitoring R #3 medications, medication self-administration, or medication storage in the residents room.	A 034		
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 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 C Based on observation and interview, the facility	A 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 038	Continued From page 15 failed to ensure that in the facility's South East Wing Hallway that the unsecured and unattended Maintenance/storage room and Housekeeping Cart, were free from safety hazards and that poisonous substances were stored in secure areas, and not accessible to residents. This deficient practice could likely result in the 38 (R #s 1-38) residents listed on the census provided by the Acting Administrator on 10/24/22 to be at risk of harm, injury, or death if residents were to enter the unsecured room and ingest/spill poisonous chemicals on themselves, trip and fall, or sustain injuries from unsafe items accessible in the unsecured and unattended room and housekeeping cart. The findings are: A. On 10/24/22 at 3:00 pm, during observation of the facility's South East Wing Storage Room, the storage room door was unlocked, open, and accessible to residents, and contained unsecured cleaning supplies and chemicals including: 1. 15 - 1-gallon bottles of germicidal bleach 2. 2 - 19 ounce cans disinfectant spray 3. 20 - 19 oz cans window and surface cleaners 4. 10 - 17 oz cans furniture polish 5. 9 - 1 quart toilet bowl cleaner/bath/shower cleaner 6. 1 - 1 quart disinfectant fabric spray 7. 3 - 32 oz. stainless steel polish 8. 4 - 32 oz. dawn dish soap 9. 1 - 1-gallon decrustant/descaling 10 - 32 oz. foam hand cleaner 11. 4 - 13.5 oz. foam hand cleaner 12. 1 - 1.33-gallon bug killer 13. 1 - gallon degreaser 14. 2 - gallon oven, grill, and fryer cleaner 15. 33 - 7 oz. spray room scents 16. 1 - 5-gallon bucket Industrial dishwasher liquid	A 038	ongoing An Inservice was conducted and every current and new employee must sign Safe Storage Chemicals Form 11/4/22 Human Resources and Director will continue to monitar. Door is checked daily by Director. Housekeepers also check door and ensure that is is LockED At All times	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY I, LLC	252 ROBERT H BRADLEY DRIVE ALAMOGORDO, NM 88310

(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 038	Continued From page 16 17. 1 - 14.2 oz Furniture polish 18. 3 - 144 oz. bottles pine cleaner 19. 5 - 1 gallon liquid deodorizer disinfectant 20. 2 - 32 oz bottles liquid deodorizer disinfectant 21. 14 - 1 gallon bottles hand sanitizer 22. 2 -16.5 oz disinfectant spray B. On 10/24/22 at 3:12 pm, during observation of the facility's South East Wing hallway, the following was observed on the unsecured housecleaning cart: 1. 3 - 32 oz toilet bowl cleaner 2. 1 - 32 oz bath and bowl cleaner 3. 2- 7 oz cans air freshener 4. 1 - 32 oz bottle toilet bowl cleaner 5. 1- 19 oz glass cleaner 6. 1 -14.2 oz can furniture polish 7. 1 - 16 oz can furniture polish 8. 1 -32 oz bottle liquid disinfectant 9. 1 - 32 oz glass cleaner 10. 1 - 32 oz can deodorizer disinfectant C. On 10/24/22 at 3:26 pm, during an interview with the Acting Administrator, she confirmed the storage room and housecleaning cart findings listed above.	A 038		