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 09/12/2022

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 an Complaint survey conducted on 09/12/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities for Adults. Complaint intake NM #60548 was investigated with deficiencies cited. Complaint intake NM #60194 was investigated with deficiencies cited. Complaint intake NM #60875 was investigated with deficiencies cited Complaint intake NM #60911 was investigated with deficiencies cited. Complaint intake NM #60407 was investigated with deficiencies cited. Census: 114	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	A 019	A 019 7 NMAC 8.2.19 Staffing Ratios 1.Staffing ratio requirements of at least 1 direct care staff member on duty per every 15 residents will be monitored by Facility Administrator. 2. Facility also began using the platform OnShift for staff schedules, call offs, and pick up of shifts to monitor staffing ratios. Facility has currently eliminated the use of agency staff as of 11/1/2022 and has remained fully staffed. 3.Facility Administrator will monitor that all call pendants will be responded to within 15 minutes or less of the pendant being pressed. 4.Facility Administrator will provide a retraining on the response times for pendants being pressed with Direct Care Staff on 4/11/2023. Record of this retraining will be kept in Direct Care Staffs personal file. New direct care staff members will receive this training on pendant response time upon hire. Record of this training will be kept in Direct Care Staffs personal file.	4/11/2023

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A 019	Continued From page 1 staff person available on the premises. (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: 7.8.2.19 A (1, 5) Based on observation and interview, the facility failed to ensure, that 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 negativity effect the safety and welfare of the 114 (R #s 1-114) residents identified on the resident census provided by the Administrator on 08/30/22, to be at risk of harm, injury if there are not adequate staffing available to assist residents.	A 019	5. Pendant reports will be reviewed daily by facility administrator and Director of Health and Wellness to ensure compliance by direct care staff.	

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A 019	Continued From page 2 The findings are: Findings related to required staffing: A. Record review of the Facility Census for the Assisted Living (AL) portion of the facility on 09/01/22 revealed there were 95 residents which would require: 1. 7 DCS on duty and awake at all times during resident waking hours. 2. 3 DCS on duty and awake at all times and 2 DCS immediately available on the premises during sleeping hours. B. Record review of the Staff Schedule for 09/01/22 for the AL portion of the facility, revealed there were only: 1. 5 DCS scheduled from 6 am-10 pm. 2. 3 DCS scheduled from 10 pm-6 am. C. On 09/01/22 at 11:07 am, during an interview with the Administrator, she confirmed that based on the number of current residents in the AL, there were not enough DCS scheduled to meet the meet the required staffing ratio for 09/01/22. She confirmed that the facility has had to use outside agency staff and that they are not listed on the schedule. Findings related to not enough DCSAMs on duty to ensure resident received their medications on time. D. On 09/01/22 at 6:50 am, during an interview with overnight DCSAM #1 upon arrival at the facility to observe the morning medication pass, she stated that daytime DCSAMs should have been at the facility at 6:00 am, however, none of them had arrived yet. DCSAM #1 was asked if the day shift DCSAM were often late and she	A 019		

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A 019	Continued From page 3 stated yes, but not this late. DCSAM #1 was asked to have the daytime DCSAMs to contact this surveyor when they arrived. E. On 09/01/22 at 7:27 am, during an interview with DCSAM #1, she stated that she usually works Sunday thru Wednesday on the 6:00 pm to 6:00 am shift, she started off as a caregiver and then became a DCSAM. She stated that DCSAM #s 2 & 3 were supposed to be at the facility at 6:00 am, however, they had still not arrived. DCSAM #1 stated that she had informed the Director of Health and Wellness (DHW) and he is trying to find someone to come in and relieve her. During the interview the Business Office Manager (BOM) arrived and asked DCSAM #1 to go ahead and start passing the morning medications. F. On 09/01/22 at 8:13 am, during observation, it was observed that the daytime DCSAMs had still not arrived. G. On 09/01/22 at 8:22 am, during an interview with the BOM, she confirmed that there was still no day shift DCSAM on site. H. On 09/01/22 at 8:28 am, during an interview with R #s 14-16 in the dining room during breakfast. R #15 reported that [redacted] was supposed to get help to the dining room, [redacted] pushed [redacted] pendant and waited over 2 hours, and no one has come to check on [redacted] so [redacted] brought [redacted] down to breakfast. R #16 stated that [redacted] is still waiting on [redacted] medications, the facility needs more help, the current nurse (DHW) claims not to be responsible. Staff are here one day gone tomorrow. R #14 also stated that [redacted] is still waiting for [redacted] medications. I. Record review of the staff schedule for	A 019		

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A 019	Continued From page 4 09/01/22, revealed that DCSAM #2 and 6 were scheduled day shift (6:00 am-6:00 pm) on 09/01/22. J. On 09/01/22 at 9:52 am, during observation, [name of resident] was observed at the door to the medication room, asking DCSAM #4 for [redacted] medications. [Name of resident] was being told by DCSAM #4 that the medications were being counted and they would be up in about 20 minutes to give [redacted] the medications. Resident was observed to be very upset and anxious. K. On 09/01/22 at 9:53 am, during an interview with DCSAM #4, she was asked if she was the scheduled dayshift DCSAM and she stated that she was not the day shift DCSAM for the Assisted Living (AL), but was up from the Memory Care Unit (MCU) to assist with the AL residents with getting their medications. L. On 09/01/22 at 9:55 am, during observation and interview with R #14 who was sitting in a chair in the lobby. [redacted] stated that [redacted] had still not received [redacted] morning medications yet and appeared to be very anxious. R #14 stated that this is what it was like, medications were often late, staff are here 1 day and gone the next. M. On 09/01/22 at 11:07 am, during an interview with the Administrator she confirmed that 3 DCSAM did not show up for work today and residents did not receive their morning medications on time. Findings related to pendant response logs: N. Record review of R #6's pendant reports for 08/09/22 through 08/25/22, revealed that	A 019		

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A 019	Continued From page 5 1. On 08/23/22 R #6's pendant was pressed at 5:40 pm with no response, then again at 6:46 pm with no response. Both instances were announced 12 times. The resident's pendant was last responded to at 3:52 pm and not again until 8:00 pm; approximately 4 hours. 2. On 08/19/22 R #6's pendant was pressed at 5:00 am, 6:00 am, 7:02 am, 8:02 am, and 9:03 am, with no response. All 5 instances were announced 12 times. The resident's pendant was last responded to at 3:34 am and not again until 10:12 am; approximately 7 hours. O. Record review of R #6's pendent reports for dates 08/09/22-8/25/22 (16 days), revealed that the resident waited a total of 2,935 minutes in instances where the response was longer than 15 minutes. In instances where the pendant was never responded to, the time waited was calculated at 60 minutes. The total times the pendant was announced (pressed) in instances where the response was longer than 15 minutes was 631 times. There was a total of 87 instances that the resident waited longer than 15 minutes during the period reviewed. When averaged, this calculates to a wait time of 33.74 minutes and 7.25 announcements per instance. P. Record review of R #7's pendant reports for 08/25/22 through 09/06/22, revealed that on 08/27/22 R #7's pendant was pressed at 8:10 pm, 9:26 pm, and again on 08/28/22 at 1:54 am with no response. All 3 instances were announced 12 times. The resident's pendant was last responded to at 10:32 am on 08/27 and not again until 3:16 am on 08/28; approximately 17 hours. Q. Record review of R #7's log for dates 8/25/22 through 09/6/22 (12 days), revealed that the resident waited a total of 988 minutes in	A 019		

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A 019	Continued From page 6 instances where the response was longer than 15 minutes. In instances where the pendant was never responded to, the time waited was calculated at 60 minutes. The total times the pendant was announced (pressed) in instances where the response was longer than 15 minutes was 207 times. There was a total of 26 instances that the resident waited longer than 15 minutes during the period reviewed. When averaged, this calculates to a wait time of 38 minutes and 7.96 announcements per instance. R. Record review of email received on 09/08/22 at 10:50 am, from the Administrator responding to being asked what is the expected response time when a resident pushes their pendant? The Administrator stated in her email that the DCS are expected to respond as soon as possible and she expects them to respond within 5 minutes.	A 019		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a	A 032	A 032 7 NMAC 8.2.32 Reporting of Incidents 1. Facility Administrator or Director of Health and Wellness will report all reportable incidents of suspected abuse, neglect or exploitation in the required 24 hour time frame in accordance with 7.1.13 NMAC and submit form Health Facility incident report (SFY 2017) to license authority. 2. Facility Administrator or Director of Health and Wellness will complete required Complaint Narrative Investigation Report (5 day follow up) following all reported incidents in accordance with 7.1.13 NMAC and submit to license authority. 3. Facility will conduct an internal investigation on all reportable incidents. 4. Facility Director of Health and Wellness, Assistant Health and Wellness Director and Memory Care Director will be retrained by facility Administrator on how to fill out Health Incident Report (SFY 2017) and Complaint Narrative Investigation Report (5 day follow up) in accordance with 7.1.13 NMAC. Retraining completed 2/21/2023 by facility Administrator.	4/1/2023

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A 032	Continued From page 7 copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure for 2 (R #s 4 & 5) of 2 (R #s 4 & 5) residents that incidents of unusual occupancies that had the potential or did result in harm and/or injury to the resident were reported to the Licensing Authority within 24 hours or the next business day, if a holiday or weekend. This deficient practice could likely result in the residents to be at risk of harm, injury or death, if incidents are not reported and the there is no oversite by the Licensing Authority. The findings are: Findings for R #4 A. Record review of Complaint Intake #60911 (received on 08/10/22) revealed the complainant reported the following:	A 032	5. Documentation of retraining on incident reporting will be kept in Directors personal file.	

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A 032	Continued From page 8 1. R #4 suffers from various physical health conditions, a recent heart attack, 23 pieces of metal in [redacted] body, and the beginning stages of [redacted] 2. On 08/06/22 at approximately 10:00 pm, the fire alarm went off for a long time and R #4 felt like [redacted] needed to get out of the building. R #4's room is on the 2nd floor of the building. 3. R #4 had to walk down the stairs with [redacted] cane, which is very difficult for [redacted] walked down the stairs and [redacted] gave out and [redacted] into some bushes, 4. R #4 stayed in the bushes for approximately 5 hours, the staff did not find [redacted] until 3:00 am. 5. When R #4 was found it took 3 staff members and approximately 1 hour for them to pick R #4 up, because [redacted] is very sensitive to pain, due to the pieces of metal in [redacted] body and to make sure the metal pieces do not move, cut into [redacted] which could cause [redacted] 6. R #4 received suffered a wound to [redacted] which the medical /staff cleaned it and covered with transparent tape. 7. The next morning 08/07/22 R #4 called [redacted] to tell [redacted] not to pick [redacted] up for church, [redacted] did not sleep much, did not feel well, and that [redacted] fell. They attempted to take [redacted] temperature, but could not because the thermometer was broken. R #4 felt warm. 8. After speaking to R #4, [redacted] was concerned and went to the facility to check on [redacted] That is when [redacted] found out what happened and observed that in addition to the wound on R #4's [redacted] had many wounds on [redacted] she took pictures of [redacted] wounds. R #4's [redacted] requested a copy of the facility's incident report for the fall at the front desk. The clerk stated that she just got to work and would ask if one was	A 032		

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A 032	Continued From page 9 filed. 9. On 08/08/22 R #4's [redacted] met with the Administrator and Director of health and Wellness (DHW) and was told that when the fire alarm went off the Direct Care Staff (DCS) notified the residents that it was a false alarm by telling the residents who came to their doors. They did not notify R #4 and other residents because they did not get up and did not want to wake [redacted] R #4's [redacted] again requested a copy of the incident report and was told they would have to check with the main office [redacted] R #4's [redacted] saw that R #4 was not feeling well and left the facility so [redacted] could rest. 10. The next day 08/09/22 (time unknown) when R #4's [redacted] went to visit the resident, [redacted] learned that [redacted] had taken R #4 to the hospital the night before, because [redacted] was not feeling well, that R #4 had suffered a [redacted] and was being admitted to the hospital. 11. R #4's [redacted] felt that R #4 was neglected by the facility and the Administrator because they did not get R #4 properly checked when [redacted] 1st fell. R #4's [redacted] believed because R #4 had to go downstairs on [redacted] own and was missing for 5 hours after [redacted] was a direct result of [redacted] and negligence by the facility staff. B. Record review of the facility's Internal Incident report dated 08/06/22 at 2:24 am, revealed there was no documentation that the following incident was reported to the Licensing Authority: 1. R #4 had an unwitnessed fall with injury. 2. R #4 was found outside the building in a bush. 3. DCS assisted R #4 to [redacted] room, got [redacted] cleaned up, wound care was done, vitals were taken, and resident was assisted to bed. a. Respirations were 14. b. Temperature was 96.2.	A 032		

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A 032	Continued From page 10 C. Blood Pressure was 163/74. d. Oxygen Saturation Level was 94. e. Pulse was 71. 4. Resident had several skin tears that need to be redressed. 5. 2-hour status checks and resident was told if [redacted] needed anything or wanted to go for a walk, but is weak to call a staff member. C. Record review of the (Direct Care who assist with medications) DCSAM #2 the description of the incident on the back of the Internal Incident report above dated 08/06/22 at 2:24 am, revealed the following; 1. DCS let the DCSAM #2 know that R #4 was calling, but was not in [redacted] 2. DCS had searched the entire 3rd floor. DCSAM #2 then went upstairs and found R #4's walker in the stairwell by [redacted] 3. All staff started looking for R #4 and when they got outside, they found R #4 in a bush with [redacted] cane. 4. Management was notified, then 2 DCS and DCSAM got resident up into [redacted] and wheeled [redacted] They helped [redacted] into clean clothes [redacted] were soaked from the rain. 5. After changing R #4, DCSAM did wound care to [redacted] that had a big skin tear, [redacted] also had a skin tear on [redacted] had a [redacted] and there was a [redacted] 6. Resident wanted to lay down and DCS assisted [redacted] 7. Resident stated for a 2nd time that [redacted] DCSAM let the former DHW know. Resident stated that [redacted] did not hit [redacted] and did not want to be sent out. D. Record review of R #4's facility Resident Notes dated 08/06/22 through 08/11/22 revealed	A 032		

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A 032	Continued From page 11 the following: 1. On 08/06/22 at 2:24 am, revealed that R #4 had a fall and was found outside in a bush at the side of the building. DCS assisted [redacted] room, helped [redacted] into clean clothes and did wound care. It was noted that R #4 had a few skin tears and scratches, vital were done, and resident was assisted to bed. There were no additional notes until 08/07/22 at 6:00 am. 2. On 08/08/22 at 7:00 pm, resident was not in [redacted] room. 3. On 08/08/22 at 7:30 pm, DCS inquired at front desk and was told the R #4 checked out of the facility at 10:30 am and had not returned. 4. On 08/09/22 at 6:25 pm, Resident still out of facility. 5. On [redacted]22 at 1:15 pm, The DHW noted that resident was admitted to hospital. 6. On [redacted]22 (time not noted). The DHW noted that resident was discharged from hospital, with 1 new medication for blood pressure. R #4 seemed a little confused about the past few days. 7. 08/12/22 (time not noted), The DHW noted that the resident was upset because [redacted] did not want to give up [redacted] new medication list. E. On 08/31/22 at 11:25 am, during an interview with the DHW regarding R #4, he confirmed that R #4 fell after the fire alarm was pulled by a resident in the MCU on the 1st floor around 10:00 pm, on 08/06/22 and was not found for approximately 5 hours. None of the DCS on duty knew the code to turn the alarm off and they had to wait for the fire department to come turn off the alarm. The DCS on duty were supposed to be doing sweeps (checks to make sure residents were accounted for). The DHW stated that currently the facility is having to use a lot of agency staff and confirmed it was mostly agency staff on duty the night of the incident. He	A 032		

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A 032	Continued From page 12 confirmed that R #4 sustained injuries to both [redacted] and that the incident was not reported to the Licensing Authority. F. On 08/31/22 at 1: 30 pm: during an Interview with R #4 in [redacted] room and [redacted] [Name of [redacted] on the phone. [redacted] assured R #4 that it was ok to talk to me, while remaining on the phone during the interview. R #4 stated that [redacted] was awakened by the fire alarm, that it was going off for a long time, no one came to check on [redacted] or to tell [redacted] is was a false alarm, so [redacted] decided to get up and get out of the building. [redacted] used [redacted] walker to get to the stairwell (was found there later by staff) and managed to get down the 2 flights of stairs and outside with [redacted] cane. R #4 stated that when [redacted] got downstairs and outside the building [redacted] were weak [redacted] is a WWII/Korea Disabled Vet and has shrapnel in [redacted] legs and body). [redacted] slid down the wall onto the ground, [redacted] got caught in the bushes, and clarified that [redacted] did not fall. [redacted] stated that [redacted] was on ground for about 5 hours and it was raining. [redacted] said the doors usually lock at 8:00 pm, but unlocked when the fire alarm went off. No discovered [redacted] until about 3:00-3:30 am. [redacted] said a Home Health Aide for another resident and [Name of Agency Caregiver]found [redacted] They rang [redacted] alert button, but it still took an hour and 3 people to get [redacted] up off the ground. R #4 reported that [redacted] was in a lot of pain. G. On 09/07/22 at 12:40 pm, during an interview with Agency Staff (AS) #1 regarding R #4 [redacted] stated that when the fire alarm went off they (AS and DCS) checked to see if everyone was in their room. The told the residents that came to their doors or were in the hallways that it was a false alarm and it was ok to stay in their rooms. AS #1	A 032		

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A 032	Continued From page 13 stated that when R #4 was found outside on the ground he took the resident's walker, and he and another AS, DCS #5. and a DCSAM arrived to assist R #4. The DCSAM told them to pick R #4 up, pu[redacted] and take [redacted] room. AS #1 did not remember the exact time the fire alarm went off. He thinks the whole process of fire alarm going off and finding R #4 took about 1-1/2 hours. AS #1 reported that he and a friend-he forgot her name (AS) thinks it was around midnight, when they found and assisted R #4 to [redacted]room. He said it did take some time after they found[redacted] but not an hour. AS #1's friend (AS), DCSAM and another staff person assisted in getting R #4 up off the ground. AS #1 said he has no idea if R #4's pendant was activated or not. H. Record review of R #4's resident file and the facility's Internal incident reports revealed no documentation of that incident on 08/06/22 for R #4 was self-reported to the Licensing Authority by the facility. I. On 09/07/22 at 1:30 pm, during an interview with the Administrator, she confirmed that facility did not self-report the 08/06/22 incident were R #4 exited the building when the fire alarm was activated by a resident in the MCU and slid down in the bushes in the rain, was not found for several hours, and suffered injuries (scrapes, cuts, skin tears) and had a heart attack during the incident or the next day to the Licensing Authority within 24 hours or the next business day if a holiday or a weekend. Findings for R #5 J. Record review of R #5's facility's Internal Incident Report revealed that the resident was	A 032		

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A 032	Continued From page 14 found deceased on the floor of [redacted] bathroom on 07/20/22 at 6:34 am. K. Record review of the facility's Self-Report to the Licensing Authority, revealed that it was not faxed/received until 07/22/22, which was not received within the required 24 hours after the incident occurred. L. On 09/01/22 at 10:24 am, during an interview with DCS #4, she stated that on 07/20/22 she went to check on R #5 to do her 1st check of the day, when she found [redacted] on the bathroom floor. The day before she did the same and escorted [redacted] to/from breakfast, lunch, and dinner. She last saw R #5 about 5:00-5:30 pm. DCS #4 stated that R #5 walked slow and that [redacted] was pushing [redacted] to walk more. R #5 was able to walk with stand-by assistance, [redacted] really did not want to walk [redacted] would get tired though [redacted] said it was good from [redacted] would walk for a short distance and then would sit down for a few minutes using [redacted] with a seat on it. When she found R #5 [redacted] on the bathroom floor [redacted] was by [redacted] chair in the living room and [redacted] was laying on the floor in the bathroom, with no clothes on from the waist down. [redacted] were on the floor and she did not see them until she was asked to check. DCS #4 stated that R #5 was fine the night before, [redacted] was talking, went down to dinner, and seemed ok. DCS #4 stated that R #5 was on 2-hour checks. M. On 09/09/22 at 8:55 am, during an interview with Administrator regarding R #5, she confirmed the facility Self-Report to the Licensing Authority dated 07/22/22 reporting [redacted] unexpected [redacted] on 07/20/22 was not submitted within 24 hours or the next the next business day if a holiday or weekend. The Administrator confirmed that R	A 032		

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A 032	Continued From page 15 #5's Evaluation and ISP did not state that [redacted] needed 2 hour checks, however, the staff had started and documented that they were doing 2-hour checks and should have been doing them regularly. She confirmed that there is no documentation that anyone checked/saw on R #5 after dinner on 07/19/22, approximately 12 hours before [redacted] was found [redacted] on [redacted] bathroom floor. The Administrator stated that R #5 did have a pendant, it was in [redacted] when found on 07/20/22, but [redacted] had not activated it. The Administrator confirmed that on the evening of 07/19/22 the responsible staff for R #5 were AS and that they may not have been aware that [redacted] needed to be checked on every 2 hours. There is no type of communication process so that the Agency staff know who the residents are and what care and services they need. The Administrator stated that the facility was only assisting R #5 with reordering [redacted] medications and that [redacted] was never entered into the electronic MAR system.	A 032		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse;	A 033	A 033 7 NMAC 8.2.33 Resident Rights 1.the Facility Administrator will monitor for compliance that all samples of any nature including COVID-19 samples will be kept in bio hazard locked refrigerator in the bio hazard room. 2.Facility Administrator will monitor for compliance that all self reported incidents are reported to the state authority in the appropriate 24 hour window utilizing the Health Incident Report (SFY 2017) . 3.Facility Administrator will retrain appropriate staff on how to fill out Health Incident Report (SFY 2017) and Complaint Narrative Investigation Report (5 day follow up) in accordance with 7.1.13 NMAC. Training completed 2/21/2023 by facility Administrator. 4.Documentation of retraining on incident reporting will be kept in Directors personal file.	2/21/2023

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A 033	Continued From page 16 (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private	A 033	5. Facility Administrator will monitor for compliance that an Assessment and ISP will be completed upon admission by facility Administrator or Director of Health and Wellness. Assessment and ISP will be updated as needed for changes to residents care needs or every six months. ISP to detail any special care needs that a resident shall need including additional care checks. Residents health care provider shall provide a physician report to include all health care needs resident will need so that can be reflected in the residents assessment and ISP. 6. Facility Administrator will retrain all medication aides on the proper use and disposal of gloves when passing medication. This retraining will be included in monthly staff meeting.	

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A 033	Continued From page 17 telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of	A 033		

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A 033	Continued From page 18 attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (4) 7.1.13.7. DEFINITIONS: T. "Neglect" means the failure of the caretaker/staff to provide basic needs of a person, such as clothing, food, shelter, supervision and care for the physical and mental health of that person. Neglect causes, or is likely to cause, harm, or death to a person. Based on record review, observation, and interview, the facility failed to ensure that residents were: 1. Provided with a safe and sanitary living	A 033		

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environment.
2. Where receiving the care and supervision needed to protect the residents physical and mental health.

These deficient practices could likely result in the 114 (R #s 1 - 114) Assisted Living (AL) and Memory Care Unit (MCU) residents identified on the census provided by the Administrator on 08/30/22, to be at risk of harm, injury, and/or death if residents are exposed to hazardous infectious materials specifically staff COVID (a contagious disease caused by severe acute respiratory syndrome coronavirus 2(SARS-CoV-2) tests.

The findings are:

Finding related to Covid-19 samples

A. On 08/30/22 at 3:25 pm, during an observation of the lobby outside elevator B, the refrigerator was observed to be unlocked and contained three staff COVID-19 test samples.

B. On 08/30/22 at 3:30 pm, during an interview with the Administrator, she confirmed that the refrigerator outside lobby B was not locked and contained three staff COVID test samples.

Findings for R #4

C. Record review of Complaint Intake #60911 (received on 08/10/22) revealed the complainant reported the following:
1. R #4 suffers from various physical health conditions, a recent heart attack, 23 pieces of metal in [redacted] body, and the beginning stages of [redacted]

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A 033	Continued From page 20 2. On 08/06/22 at approximately 10:00 pm, the fire alarm went off for a long time and R #4 felt like[redacted] needed to get out of the building. R #4's room is on the 2nd floor of the building. 3. R #4 had to walk down the stairs with[redacted] cane, which is very difficult for[redacted] walked down the stairs and[redacted] gave out and[redacted] into some bushes. 4. R #4 stayed in the bushes for approximately 5 hours, the staff did not find[redacted] until 3:00 am. 5. When R #4 was found it took 3 staff members and approximately 1 hour for them to pick R #4 up, because[redacted] is very sensitive to pain, due to the pieces of metal in[redacted] body and to make sure the metal pieces do not move, cut into[redacted] which could cause[redacted] 6. R #4 suffered a wound to[redacted] which the medical /staff cleaned it and covered with transparent tape. 7. The next morning on 08/07/22, R #4 called[redacted] to tell her not to pick[redacted] up for church, [redacted] did not sleep much, did not feel well, and that [redacted] fell. They attempted to take [redacted] temperature, but could not because the thermometer was broken. R #4 felt warm. 8. After speaking to R #4,[redacted] was concerned and went to the facility to check on [redacted] That is when she found out what happened and observed that in addition to the wound on R #4's[redacted] had many wounds on[redacted] was [redacted] and[redacted] had scratches on[redacted] and she took pictures of[redacted] wounds. R #4's[redacted] requested a copy of the facility's incident report for the fall at the front desk. The clerk stated that she just got to work and would ask if one was filed. 9. On 08/08/22 R #4's[redacted] met with the Administrator and Director of health and Wellness (DHW) and was told that when the fire alarm	A 033		

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A 033	Continued From page 21 went off the Direct Care Staff (DCS) notified the residents that it was a false alarm by telling the residents who came to their doors. They did not notify R #4 and other residents because they did not get up and did not want to wake [redacted] R #4's [redacted] again requested a copy of the incident report and was told they would have to check with the main office [redacted] believed [redacted] was getting the runaround). R #4's [redacted] saw that R #4 was not feeling well and left the facility so [redacted] could rest. 10. The next day 08/09/22 (time unknown) when R #4's [redacted] went to visit the resident, [redacted] learned that [redacted] had taken R #4 to the hospital the night before, because [redacted] was not feeling well, that R #4 had suffered a heart attack, and was being admitted to the hospital. 11. R #4's [redacted] felt that R #4 was neglected by the facility and the Administrator because they did not get R #4 properly checked when [redacted] 1st fell. R #4's [redacted] believed because R #4 had to go downstairs on [redacted] own and was missing for 5 hours after [redacted] fall was a direct result of [redacted] heart attack and negligence by the facility staff. D. Record review of the facility's Internal Incident Report dated 08/06/22 at 2:24 am, revealed there was no documentation that the following incident was reported to the Licensing Authority: 1. R #4 had an unwitnessed fall with injury. 2. R #4 was found outside the building in a bush. 3. DCS assisted R #4 to [redacted] room, got [redacted] cleaned up, wound care was done, vitals were taken, and resident was assisted to bed. a. Respirations were 14. b. Temperature was 96.2. C. Blood Pressure was 163/74. d. Oxygen Saturation Level was 94. e. Pulse was 71. 4. Resident had several skin tears that need to	A 033		

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A 033	Continued From page 22 be redressed. 5. 2-hour status checks and resident was told if [redacted] needed anything or wanted to go for a walk, but is weak to call a staff member. E. Record review of the (Direct Care who assist with medications) DCSAM #2 the description of the incident on the back of the Internal Incident report above dated 08/06/22 at 2:24 am, revealed the following; 1. DCS let the DCSAM #2 know that R #4 was calling, but was not in [redacted] room. 2. DCS had searched the entire 3rd floor. DCSAM #2 then went upstairs and found R #4's walker in the stairwell by [redacted] room. 3. All staff started looking for R #4 and when they got outside, they found R #4 in a bush with [redacted] cane. 4. Management was notified, then 2 DCS and DCSAM got resident up into [redacted] walker and wheeled [redacted] They helped [redacted] into clean clothes [redacted] were soaked from the rain. 5. After changing R #4, DCSAM did wound care to [redacted] that had a big skin tear, [redacted] also had a skin tear on [redacted] had a rash and scratches and there was a skin tear to [redacted] 6. Resident wanted to lay down and DCS assisted him. 7. Resident stated for a 2nd time that [redacted] felt numb. DCSAM let the former DHW know. Resident stated that [redacted] did not hit [redacted] head and did not want to be sent out. F. Record review of R #4's facility Resident Notes dated 08/06/22 through 08/11/22 revealed the following: 1. On 08/06/22 at 2:24 am, revealed that R #4 had a fall and was found outside in a bush at the side of the building. DCS assisted [redacted]	A 033		

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	7117	A. BUILDING: _____ B. WING _____	C 09/12/2022

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A 033	Continued From page 23 room, helped [redacted] into clean clothes and did wound care. It was noted that R #4 had a few skin tears and scratches, vital were done, and resident was assisted to bed. There were no additional notes until 08/07/22 at 6:00 am. 2. On 08/08/22 at 7:00 pm, resident was not in [redacted] room. 3. On 08/08/22 at 7:30 pm, DCS inquired at front desk and was told the R #4 checked out of the facility at 10:30 am and had not returned. 4. On 08/09/22 at 6:25 pm, Resident still out of facility. 5. On 08/10/22 at 1:15 pm, The DHW noted that resident was admitted to hospital. 6. On 08/11/22 (time not noted). The DHW noted that resident was discharged from hospital, with 1 new medication for blood pressure. R #4 seemed a little confused about the past few days. 7. 08/12/22 (time not noted), The DHW noted that the resident was upset because [redacted] did not want to give up [redacted] new medication list. G. On 08/31/22 at 11:25 am, during an interview with the DHW regarding R #4, he confirmed that R #4 fell after the fire alarm was pulled by a resident in the MCU on the 1st floor around 10:00 pm, on 08/06/22 and was not found for approximately 5 hours. None of the DCS on duty knew the code to turn the alarm off and they had to wait for the fire department to come turn off the alarm. The DCS on duty were supposed to be doing sweeps (checks to make sure residents were accounted for). The DHW stated that currently the facility is having to use a lot of agency staff and confirmed it was mostly agency staff on duty the night of the incident. He confirmed that R #4 sustained injuries to both [redacted] [redacted] scratches/bruises/lacerations) and that the incident was not reported to the Licensing Authority.	A 033		

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A 033	Continued From page 24 H. On 08/31/22 at 1: 30 pm: during an Interview with R #4 in [redacted] room and [redacted] [Name of [redacted] on the phone, [redacted] assured R #4 that it was ok to talk to me, while remaining on the phone during the interview. R #4 stated that [redacted] was awakened by the fire alarm, that it was going off for a long time, no one came to check on [redacted] or to tell [redacted] is was a false alarm, so [redacted] decided to get up and get out of the building [redacted] used [redacted] walker to get to the stairwell (was found there later by staff) and managed to get down the 2 flights of stairs and outside with [redacted] cane. R #4 stated that when [redacted] got downstairs and outside the building [redacted] were weak [redacted] is a WWII/Korea Disabled Vet and has [redacted] slid down the wall onto the ground [redacted] got caught in the bushes, and clarified that [redacted] did not fall. [redacted] stated that [redacted] was on ground for about 5 hours and it was raining. [redacted] said the doors usually lock at 8:00 pm, but unlocked when the fire alarm went off. No discovered [redacted] until about 3:00-3:30 am. [redacted] said a Home Health Aide for another resident and [Name of Agency Caregiver]found [redacted] They rang [redacted] alert button, but it still took an hour and 3 people to get [redacted] up off the ground. R #4 reported that [redacted] was in a lot of pain. I. On 09/07/22 at 12:40 pm, during an interview with Agency Staff (AS) #1 regarding R #4, he stated that when the fire alarm went off they (AS and DCS) checked to see if everyone was in their room. The told the residents that came to their doors or were in the hallways that it was a false alarm and it was ok to stay in their rooms. AS #1 stated that when R #4 was found outside on the ground he took the resident's walker, and he and another AS, DCS #5. and a DCSAM arrived to assist R #4. The DCSAM told them to pick R #4	A 033		

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A 033	Continued From page 25 up, put [redacted] walker, and take [redacted] room. AS #1 did not remember the exact time the fire alarm went off. He thinks the whole process of fire alarm going off and finding R #4 took about 1-1/2 hours. AS #1 reported that he and a friend-he forgot her name (AS) thinks it was around midnight, when they found and assisted R #4 to [redacted] room. He said it did take some time after they found [redacted] but not an hour. AS #1's friend (AS), DCSAM and another staff person assisted in getting R #4 up off the ground. AS #1 said he has no idea if R #4's pendant was activated or not. J. Record review of the [Name of Hospital] Physician's Progress Notes dated 08/11/22, revealed that R #4 was admitted to the hospital on 08/08/23 noted the following: 1. R #4 was initially admitted due to recurring falls. 2. He was found to have elevated heart enzymes, with no changes on EKG, suggesting and active heart attack. 3. This is called a non-ST-elevation myocardial infarction (a type of heart attack that usually happens when your heart ' s need for oxygen can ' t be met. define) and is an acute coronary syndrome. 4. R #4 also had high blood pressure during [redacted] admission. K. Record review of R #4's resident file and the facility's Internal incident reports revealed no documentation of that incident on 08/06/22 for R #4 was self-reported to the Licensing Authority by the facility. L. On 09/07/22 at 1:30 pm, during an interview with the Administrator, she confirmed that facility did not self-report the 08/06/22 incident were R	A 033		

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A 033	Continued From page 26 #4 exited the building when the fire alarm was activated by a resident in the MCU and slid down in the bushes in the rain, was not found for several hours, and suffered injuries (scrapes, cuts, skin tears) and had a heart attach during the incident or the next day to the Licensing Authority within 24 hours or the next business day if a holiday or a weekend. Finding related to R #5 M. On 09/01/22 at 10:24 am, during an interview with DCS #4, she stated that she went to do her 1st check of the day on R #5, when she found [redacted] on the bathroom floor. The day before she did the same and escorted [redacted] to/from breakfast, lunch, and dinner. She last saw R #5 about 5:00-5:30 pm on 07/19/22. DCS #4 stated that R #5 walked slow and that [redacted] was pushing [redacted] to walk more. R #5 was able to walk with stand-by assistance [redacted] really did not want to walk [redacted] would get tired though [redacted] said it was good from [redacted] would walk for a short distance and then would sit down for a few minutes using [redacted] walker with a seat on it. When she found R #5 [redacted] on the bathroom floor [redacted] walker was by [redacted] chair in the living room, and [redacted] was laying on the floor in the bathroom, with no clothes on from the waist down. [redacted] were on the floor from the waist down and she did not see them until she was asked to check. DCS #4 stated that R #5 was fine the night before [redacted] was talking, N. Record review R #5's 2-hour Status Check sheets dated 06/26/22 through 07/19/22 revealed that on 2 occasions it was noted that the DCSAM brought (assisted) R #5 [redacted] medications and that only the following status checks were noted by the DCS:	A 033		

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A 033	Continued From page 27 1. 06/26/22: a. 3:14 (no am/pm listed). b. 7:33 pm C. 10:06 pm d. 2:17 pm e. 5:06 pm 2. 06/27/22: a. 1:59 pm b. 8:00 pm 3. 06/28/22: a. 12:30 am b. 9:05 am 4. 06/29/22: a. unreadable am. b. 1:15 pm C. 3:30 pm d. 10:09 pm 5. 06/30/22: a. 12:15 am b. 2:35 am C. 4:10 am 6. 07/18/22: a. 8:30 am. Note AM Meds b. 9:40 am C. 11:15 am d. 1:15 (not am/pm) e. 2:00 pm f. 4:32 pm g. 7:40 pm 7. 07/19/22: a. 7:10 am b. 7:41 am C. 9:52 am d. 11:37 am e. 2:00 pm f. 4:15 pm g. 4:20 pm. Note PM Meds. O. On 09/09/22 at 8:55 am, during an interview with Administrator regarding R #5, she confirmed	A 033		

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A 033	Continued From page 28 the following, that: 1. The facility Self-Report to the Licensing Authority dated 07/22/22 reporting his unexpected death on 07/20/22 was not submitted within 24 hours or the next the next business day if a holiday or weekend. 2. R #5's Evaluation and ISP did not state that he needed 2-Hour Status Checks, however, the DCS had started and documented that they were doing 2-hour checks and should have been doing them regularly. 3. There is no documentation that anyone checked on or saw on R #5 after dinner on 07/19/22, approximately 12 hours before [redacted] was found [redacted] bathroom floor. The Administrator stated that R #5 did have a pendant, it was in [redacted] hand when found on 07/20/22, but he had not activated it. 4. On the evening of 07/19/22 the responsible staff for R #5 were AS and that they may not have been aware that [redacted] needed to be checked on every 2 hours. There is no type of communication process so that AS would know who the residents are and what care and services they need. 5. The facility was only assisting R #5 with reordering [redacted] medications and that [redacted] was never entered into the electronic MAR system. P. Record review of R #5's physician's order (not dated) for oxygen, revealed that at some point [redacted] was supposed to be on oxygen. However, it was not received or put in place prior to R #5 passing away. The Administrator stated that the facility was working on getting R #5's oxygen set up, but it had not yet been received. She stated that it had been less than a month since they received the order. Q. On 09/09/22 at 10:16 am, during an interview with the DHW regarding R #5 he stated that the	A 033		

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A 033	Continued From page 29 facility was assisting R #5 with [redacted] medications. He did not know the start date. According to the DHW all resident medications should be reordered within 7-days before running out. R. On 09/09/22 at 11:50 am, during an interview with DCS #s 2 and 5, they both remember assisting R #5 with [redacted] medications just before [redacted] and there should be a paper MAR somewhere. Finding related to late medications. S. On 09/01/22 at 6:50 am, during an interview with overnight DCSAM #1 upon arrival at the facility to observe the morning medication pass, stated that daytime DCSAM's should have been at the facility at 6:00 am, however, none of them had arrived yet. DCSAM #1 was asked if the day shift med aides were often late and she stated yes, but not this late. DCSAM was asked to have the daytime DCSAMs to contact surveyor when they arrived. T. On 09/01/22 at 7:27 am, during an interview with DCSAM #1, she stated that she usually works Sunday thru Wednesday the 6:00 pm to 6:00 am shift, she started off as a caregiver and then became a DCSAM. She stated that DCSAM #s 2 & 3 were supposed to be at the facility at 6:00 am, however, they had still not arrived. DCSAM #1 stated that she had informed the DHW and he is trying to find someone to come in and relieve her. During the interview the Business Office Manager (BOM) arrived and asked DCSAM to go ahead and start passing the morning medications. U. On 09/01/22 at 8:13 am, during observation, it was observed that the daytime DCSAM had still	A 033		

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A 033	Continued From page 30 not arrived. V. On 09/01/22 at 8:22 am, during an interview with the BOM, she confirmed that there was still no day shift DCSAM on site. W. On 09/01/22 at 8:28 am, during an interview with R #s 14-16 in the dining room during breakfast. R #16 stated that [redacted] is still waiting on [redacted] medications, the facility needs more help, the current nurse claims not to be responsible. Staff are here one day gone tomorrow. R #14 also stated that [redacted] is still waiting for [redacted] medications. X. Record review of the staff schedule for 09/01/22, revealed that DCSAM #s 2 and 6 were scheduled day shift (6:00 am-6:00 pm) on 09/01/22. Y. On 09/01/22 at 9:52 am, during observation, [name of resident] was observed at the door to the medication room, asking DCSAM #4 for [redacted] medications. [Name of resident] was being told by DCSAM #4 that the medications were being counted and they would be up in about 20 minutes to give [redacted] the medications. Resident was observed to be very upset. Z. On 09/01/22 at 9:53 am, during an interview with DCSAM #4, she was asked if she was the scheduled dayshift DCSAM and she stated that she was not the day shift DCSAM for the Assisted Living (AL), but was up from the Memory Care Unit to assist with the AL residents with their medications. AA. On 09/01/22 at 9:55 am, during observation and interview with R #14 who was sitting in a chair in the lobby. She stated that she had still not received [redacted] morning medications yet and	A 033		

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A 033	Continued From page 31 appeared to be very anxious. R #14 stated that this is what it was like, medications were often late, staff was here 1 day and gone the next. Finding related to touching of medications BB. On 09/08/22 at 7:13 am, during observation of the medication pass for R #s 17 and 18, DCSAM #2 was observed touching a pill that would not come out of the bottle with her gloved hand that had touched the medication cart, computer, medication bottles/bubble, and other unsanitary surfaces. CC. On 09/07/22 at 7:15 am, during an interview with DCSAM #2, she confirmed that she touched the pill with her gloved hand after touching other unsanitary surfaces.	A 033		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s	A 035	A 035 7 NMAC 8.2.35 Medication 1.Facility Administrator and Health and Wellness Director will audit all MARS to ensure that medication aides are administrating all medication at the appropriate times and in the proper manner. 2.All medication aides will be retrained on how to properly read the MARS and proper administration of medication on 3/31/2023. Record of this retraining will be kept in direct care staffs personal file.	3/31/2023

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A 035	Continued From page 32 designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of	A 035		

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A 035	Continued From page 33 the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication;	A 035		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 035	Continued From page 34 (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]	A 035		

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 09/12/2022

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A 035	Continued From page 35 This REQUIREMENT is not met as evidenced by: 7.8.2.35 Based on record review and interview the facility failed to ensure for 2 (R #s 2 and 9) of 2 (R #s 2 and 9) residents whose Medication Admission Records (MARs) were reviewed for compliance that medications listed on the MARs were being given as written on the MAR. This deficient practice could likely result in the residents being at risk of harm or illness, if medications are not given as ordered by the physician and adverse reactions and of/health complications occur. The findings are: Findings related to R #2: A. Record review of a Complaint Intake #60875 dated 08/15/22, revealed, that the complainant reported that R #2 did not receive [redacted] morning medication at the correct time on 08/09/22. B. Record review of the Medication Administration Record (MAR) shows that on 08/09/22. R #2 was given [redacted] at 2:26 am, and not at it's scheduled time of 6:00 am. It is to be given one (1) tablet by mouth every day before a meal. C. On 09/07/22 at 2:00 pm, during an interview with the Administrator, she confirmed that the exceptions on the MAR do show medications that	A 035		

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A 035	Continued From page 36 are late, early or if they are refused or if another exception is given. D. On 09/07/22 at 2:22 pm, during an interview with R #2, she confirmed that on 08/09/22 she received [redacted] at 2:26 am, instead of 6:00 am, before [redacted] morning meal. E. Record review of R #9's August, 2022 MAR revealed, that the order on the MAR stated that R #9 was to be receiving [redacted] on Sunday, Monday, Wednesday, Thursday, Friday, and Saturday at 1900 hours (7:00 pm) and at least 4-6 hours from receiving [redacted] F. Record review of R #9's August, 2022 MAR revealed, that the resident received [redacted] every morning at 8:00 am, except for 08/29/22. G. Record review of R #9's August, 2022 MAR revealed, that the resident received [redacted] at the same time as the [redacted] on the following dates at 8:00 am: 1. Monday 08/01/22 2. Thursday 08/04/22 3. Sunday 08/07/22 4. Wednesday 08/10/22 5. Saturday 08/13/22 6. Tuesday 08/16/22 7. Friday 08/19/22 8. Monday 08/22/22 9. Thursday 08/25/22 10. Sunday 08/28/22	A 035		

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A 035	Continued From page 37 11. Wednesday 08/31/22 H. Record review of R #9's MAR dated 09/01/22 thru 09/08/22, revealed that the order on the MAR stated that R #9 was to be receiving [redacted] on Sunday, Monday. Wednesday, Thursday, Friday, and Saturday at 1900 hours (7:00 pm) and at least 4-6 hours from receiving [redacted] I. Record review of R #9's MAR dated 09/01/22 thru 09/08/22, revealed that the resident received [redacted] on the following days at 8:00 am: 1. Thursday 09/01/22 2. Friday 09/02/22 3. Saturday 09/03/22 4. Sunday 09/04/22 5. Monday 09/05/22 6. Tuesday 09/06/22 7. Wednesday 09/07/22 8. Thursday 09/08/22 J. Record review of R #9's MAR dated 09/01/22 thru 09/08/22, revealed that the resident received [redacted] at the same time as the [redacted] on the following dates at 8:00 am: 1. Saturday 09/03/22 2. Tuesday 09/06/22 K. On 09/09/22 at 11:32 am, during an interview with the Administrator, she confirmed that that R #9 was not being given [redacted] as ordered by the physician. L. On 09/09/22 at 11:50 am, during an interview with DCSAM #s 2 and 5, they confirmed that R #9 was getting [redacted] medication in the mornings daily, instead of following the current physician's orders as stated on the August and	A 035		

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A 035	Continued From page 38 September 2022 MARS and stated "maybe that is why [redacted] keeps running out." M. On 09/09/22 at 2:00 pm, during an interview with the Administrator, she confirmed that the last refill of R #9's [redacted] only contained 24 pills, but was signed in as receiving 30 pills. The Administrator stated she does not know how often R #9 has [redacted] done [redacted]	A 035		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills.	A 065	A 065 7 NMAC 8.2.65 Fire Drills 1.Facilitys Maintenance Director will have an orientation on Fire safety and evacuation process upon move in with resident. Record of this will be kept in residents personal file. Monthly resident meeting will include an overview of the Fire and Safety and evacuation process with all residents. 2.Facility's Maintnence Director will conduct monthly fire and safety evacuation drills with all staff, rotating through each shift. Residents will be encouraged to participate in fire drills and practice evacuations will take place according to floors. Record of all Fire Drills will be kept in Maintenance Directors office in Fire Safety and Evacuation Binder. A log will be kept of each active participants name of the day of and time of fire drill. 3.Facility has eliminated the use of Agency staff as of 11/1/2022.	4/12/2023

Division of Health Improvement

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A 065	Continued From page 39 [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.3.65 B (3 & 5). Based on record review and interview the facility failed to ensure that the monthly fire drill records included the following required information: 1. Evacuation time in total minutes. 2. The number of staff who participated in the the drill. This deficient practice could likely result in the 114 (R #s 1-114) residents identified on the resident census provided by the Administrator on 08/30/22, to be at risk of harm, injury, or death if a fire or other emergency that required evacuation and: 1. The staff do not know how long it will take to evacuated the residents from the facility. 2. If there are staff who do not know how to safely evacuate the residents, because the facility is not tracking which staff have participated in the monthly drills. The findings are: A. Record review of the facility's Fire Drill Reports dated 01/12/22 through 08/16/22, revealed they did not include the following required information: 1. 01/12/22 at 10:19 am. (Stated: drill was for all): a. The Evacuation time in minutes (noted: stated "not time for yearly"-No evacuation conducted).	A 065		

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A 065	Continued From page 40 b. The number of staff who participated in the drill. 2. 02/17/22 at 3:43 pm. (Stated: drill was for 1st floor Memory Care): a. The evacuation time in minutes (noted: "not time for yearly"-No evacuation conducted). b. The number of staff who participated in the drill. 3. 03/18/22 at 1:08 am. (Stated: drill was for all): a. The evacuation time in minutes (noted: "not time for yearly"-No evacuation conducted). b. The number of staff who participated in the drill. 4. 04/14/22 at 9:45 am/pm-unknown. (Stated: drill was for all): a. The evacuation time in minutes (noted: "not time for yearly"-No evacuation conducted). b. The number of staff who participated in the drill. 5. 05/03/22 at 1:30 am. (Stated: drill was for 1st floor MC, pull station SW corner): a. The evacuation time in minutes (noted: "not time for yearly"-No evacuation conducted). b. The number of staff who participated in the drill. 6. 06/23/22 at 6:30 pm. (Stated: drill was for 3rd floor pull station): a. The evacuation time in minutes (noted: "not time for yearly"-No evacuation conducted). b. The number of staff who participated in the drill. 7. 07/18/22 at 4:00 am. (Stated drill was for all): a. The evacuation time in minutes (noted: "not time for yearly"-No evacuation conducted). b. The number of staff who participated in the drill. 8. 08/16/22 at 11:00 am. (Stated drill was for 2nd floor): a. The evacuation time in minutes (noted: "not time for yearly"-No evacuation conducted).	A 065		

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A 065	Continued From page 41 b. The number of staff who participated in the drill. B. On 08/31/22 at 2:45 pm, during an Interview with the Maintenance Director. he confirmed that the Fire Drill Reports listed above did not include: 1. The evacuation time in minutes and stated that the facility has not been doing evacuations during the monthly fire drills, due to the covid-pandemic. 2. The number of staff who participated in the drills and stated that he has not been keeping track of the names of the staff who participate in the monthly fire drills and confirmed that the agency staff are not trained in what to do if the alarm goes off and if a fire or emergency occurs that requires evacuation.	A 065		