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 07/18/2022

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 Initial/Complaint survey conducted on 07/18/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities for Adults. Complaint NM #59640 was unsubstantiated with no deficiencies cited. Complaint NM #59273 was substantiated with deficiencies cited. Complaint NM #57262 was substantiated with deficiencies cited. Complaint NM #57866 was unsubstantiated with no deficiencies cited. Complaint NM #59808 was unsubstantiated with deficiencies cited. Definitions, Acronyms, Abbreviations: ac: Before meals ALF: Assisted Living Facility AWD: Assistant Wellness Director B: Before breakfast BID: Two times daily BP: Blood pressure Carbon Monoxide Poisoning: A life-threatening emergency that occurs from inhaling carbon monoxide (CO) fumes. Carbon monoxide poisoning is a potentially fatal illness that occurs when carbon monoxide gas builds up in the blood. When carbon monoxide is inhaled, it replaces oxygen attached to the pigment hemoglobin in the blood. This hampers the delivery of oxygen to various tissues in the body, which can lead to serious damage and even death. CDC: Centers for Disease Control COVID-19: A virus known as COVID-19, a mild to severe illness that is caused by a novel corona	A 000		

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A 000	Continued From page 1	A 000		

virus which is thought to be transmitted person to person chiefly by contact with infectious material (such as respiratory droplets), and is characterized especially by fever, cough, sore throat, shortness of breath, blood clots, mental fog, and other symptoms that may progress to pneumonia, respiratory failure etc.
DC'd: Discontinued
DCS: Direct Care Staff
DCSAM: Direct Care Staff that Assist with Medications
DR (Rx): Delayed Release
Eval: Evaluation & Assessment (Service Plan as identified by Administrator)
ER: Emergency Room
ER (Rx): Extended Release
F: Fahrenheit
F/C: Film Coated
FDCS: Former Direct Care Staff
g: gram
HBP: High Blood Pressure
HCL: Hydrochloride form of acid
Hoyer Lift: A lift used by caregivers to safely transfer patients.
HS: Evening
ISP: Individual Service Plan. (Service Plan - Full as identified by Administrator)
LA: Licensing Authority
lb. Pound
LPN: Licensed Practical Nurse
MAR: Medical Administration Record
MEQ: milliequivalent
mcg: micrograms
MCU: Memory Care Unit
mg: milligram
ml: milliliters
Myasthenia gravis: Characterized by weakness and rapid fatigue of any of the muscles under your voluntary control. It's caused by a breakdown in the normal communication between

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A 000	Continued From page 2 nerves and muscles. MS: Multiple Sclerosis is a potentially disabling disease of the brain and spinal cord (central nervous system). NU: Name Unknown O2: Oxygen oz.: Ounce pc: After meals Pkg.: Package PO: By Mouth POA: Power of Attorney PRN: Pro Re Nata (as needed) Q6h: Every 6 hours qd: Daily qam: Every morning Resp: Respirations RN: Registered Nurse Rx: Prescription R: Resident Service Plan: Evaluation and Assessment per Administrator Serpvice Plan - Full: ISP per Administrator ST: Status Checks SOD: Sodium Tab: Tablet Temp: Temporary/Agency staff TID: Three times daily ULN: Unknown Last Name	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;	A 016	A 016- 7 NMAC 8.2.16 Staff Qualifications 1.Facility Administrator will ensure that Each Employee will have required background check and fingerprints within 20 days of hire through the NMDOH Caregivers and Criminal History Screening program CCHSP. 2.All pre-existing employees of Atria Vista Del Rio received background check and fingerprinting as current ownership Morada Albuquerque staff through the NMDOH Caregivers and Criminal History Screening program CCHSP. This was completed on 12/31/2022	12/31/2022

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A 016	Continued From page 3 (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. 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	A 016	3. Facility Business office manager will ensure that all future staff complete required fingerprinting and background check through NMDOH Caregivers Criminal History Screening program CCHSP within 20 days of hire.	

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A 016	Continued From page 4 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] This REQUIREMENT is not met as evidenced by: 7.8.2.16 B (7) 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: . . . D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy	A 016		

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A 016	Continued From page 5 of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. 2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. . . . E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department	A 016		

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A 016	Continued From page 6 unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. 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 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	A 016		

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A 016	Continued From page 7 provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview, the facility failed to ensure that the Direct Care Staff applications and fingerprints were submitted to the Caregivers Criminal History Screening Program (CCHSP) within 20 days of hire. This deficient practice could likely negatively affect the safety and welfare of the 118 (R #s 1-118) residents listed on the census provided by the Administrator on 06/23/22, if they are being provided care and services by Direct Care Staff (DCS) who have a criminal background. The findings are: A. Record review of the Business Director's employee file (date of hire 06/03/16), revealed no documentation that her application and fingerprints were submitted to the CCHSP within 20 days of hire by the new facility ownership on 02/01/21. B. Record review of the Sales Promotion Director's employee file (date of hire 05/27/15), revealed no documentation that his application and fingerprints were submitted to the CCHSP within 20 days of hire by the new facility ownership on 02/01/21. C. Record review of Cook #1's employee file (date of hire 05/10/06), revealed no documentation that his application and fingerprints were submitted to the CCHSP within 20 days of hire by the new facility ownership on 02/01/21.	A 016		

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A 016	Continued From page 8 D. Record review of DCS #4's employee file (date of hire 03/07/21), revealed no documentation that her application and fingerprints were submitted to the CCHSP within 20 days of hire by the new facility ownership on 02/01/21. E. Record review of DCS #10's employee file (date of hire 06/22/20), revealed no documentation that her application and fingerprints were submitted to the CCHSP within 20 days of hire by the new facility ownership on 02/01/21. F. On 07/07/22 at 10:31 am, during an interview with the Business Manager, she confirmed that there was no documentation that the facility resubmitted the above DCS's applications and fingerprints to the CCHSP within 20 days of hire by the new facility owners 02/01/21.	A 016		
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	A 017 7NMAC 8.2 17 Staff Training 1. All staff will receive 12 hours of training and orientation upon hire using the Relias program. All documentation of these trainings will printed and kept in staff members personal file. 2. All Staff will repeat 12 hours of training and orientation annually using the Relias program. All Documentation of these trainings will be printed and kept in staff members personal file. 3. The Direct Care staff will receive 16 hours of on the floor orientation and training prior to unsupervised care of residents. Documentation of this will be kept in each Direct Care Staff members file. 4. The Business office manger will manage a list of all staff and when they are due for their annual orientation and training on Relias program. Reminders will be given to staff as well as a	4/1/2023

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A 017	Continued From page 9 (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 B Based on record review and interview the facility failed to ensure there was documentation on file that the Direct Care Staff (DCS) received sixteen (16- hours) of supervised training prior to providing unsupervised care. This deficient practice could likely result in the 118 (R #s 1-118) residents listed on the resident	A 017	completion date. 5. The Facility Administrator and Business office manager will review staff files monthly to ensure that all trainings are up to date.	

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A 017	Continued From page 10 census, provided by the Administrator on 06/23/22, to be at risk of harm if they are receiving care and services by DCS who have not received the required training. The findings are: A. Record review of DCS #4's (hire date 03/07/21) training files, revealed no documentation of completing the sixteen (16) hours of supervised training, prior to providing unsupervised care for residents. B. Record review of DCS #10's (hire date 06/22/20) training files, revealed no documentation of completing the sixteen (16) hours of supervised training, prior to providing unsupervised care for residents. C. Record review of DCS #20's (hire date 04/03/06) training files, revealed no documentation of completing the sixteen (16) hours of supervised training, prior to providing unsupervised care for residents. D. Record review of DCS #21's (hire date 11/23/19) training files, revealed no documentation of completing the sixteen (16) hours of supervised training, prior to providing unsupervised care for residents. E. On 07/07/22 at 2:10 pm, during an interview with the Business Director, she confirmed that there was no documentation on file of DCS #'s 4, 10, 20, and 21 having completed the required 16-hours of supervised training.	A 017		
A 020	7 NMAC 8.2.20 Admissions and Discharge	A 020	A 020 7 NMAC 8.2 20 Admissions and Discharge	

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A 020	Continued From page 11 ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement;	A 020	1.Morada Albuquerque residency agreement has been updated on 2/1/2023 to include all components required by NMAC 7.8 20 including facilities bed hold policy on pg.14 item 11. 2.The Administrator of Morada Albuquerque will provide the resident or POA a new Morada Albuquerque residency agreement or an addendum with a request for signature. This will include residents who were residents under previous ownership Atria Vista Del Rio as well as any resident who moved in with current ownership Morada Albuquerque prior to 2/1/2023. The new residency agreement or addendum will include change of ownership and the bed hold policy. 3.A copy of the signed residency agreement will be kept in residents financial file.	6/1/2023

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A 020	Continued From page 12 (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care;	A 020		

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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 020	Continued From page 13 (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall	A 020		

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A 020	Continued From page 14 maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (11) Based on record review and interview the facility failed to ensure for 5 (R #s 1, 5, 8, 9, and 10) of 15 (R #s 1 - 15) residents whose Admission Agreements were reviewed for compliance that	A 020		

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A 020	Continued From page 15 they: 1. Were updated when a change in ownership occurred on 02/01/21. 2. Included the facility's bed hold policy These deficient practices could likely result in: 1. The residents not being aware of any changes in care, services, or cost that might occur when there was a change of ownership. 2. The residents not being aware of whether they will have a bed to return to if they have to go to the hospital or take a temporary leave from the facility. The findings are: A. Record review of R #1's resident file revealed no documentation that the: 1. Admission Agreement dated [redacted]19 was updated and new signatures obtained by all parties involved when change of ownership occurred on 02/01/21. 2. Bed hold policy was included in the admission agreement dated [redacted]19. B. Record review of R #5's resident file revealed no documentation that the: 1. Admission Agreement dated [redacted]18 was updated and new signatures obtained by all parties involved when change of ownership occurred on 02/01/21. 2. Bed hold policy was included in the admission agreement dated [redacted]18. C. Record review of R #8's resident file revealed no documentation that the bed hold policy was included in the Admission Agreement dated [redacted]21. D. Record review of R #9's resident file revealed	A 020		

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A 020	Continued From page 16 no documentation that the: 1. Admission Agreement dated [redacted]18 was updated and new signatures obtained by all parties involved when change of ownership occurred on 02/01/21. 2. Bed hold policy was included in the Admission Agreement dated [redacted]18. E. Record review of R #10's resident file revealed no documentation that the bed hold policy was included in the admission agreement dated [redacted]21. F. On 07/08/22 at 2:44 pm, during an interview with the Assistant Wellness Director, she confirmed that: 1. The Admission Agreements for R #s 1, 5, 9 and 10 had not been updated when the change of ownership occurred on [redacted]/21. 2. There was no bed hold policy in the Admission Agreements for R #s 1, 5, 8, 9 and 10. G. On 07/18/22 at 10:52 am, during an interview at the exit conference with the Administrator she confirmed that: 1. The Admission Agreements for R #s 1, 5, 9, and 10 had not been updated when the change of ownership occurred on [redacted]/21. 2. There was no bed hold policy in the Admission Agreements for R #s 1, 5, 8, 9, and 10.	A 020		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and	A 021	A 021 7NMAC 8.2.21 Resident Records 1.Facility Business office manger or Assistant business office manger will take a photo of resident at time of residency agreement signing. Photo will be provided to direct care staff and placed in residents personal file. 2.Updated photos of each current resident will be placed in personal file annually on anniversary date of move in by facility Business	2/28/23

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A 021	Continued From page 17 authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood;	A 021	Office Manager and Facility Administrator. 3. Assistant Business office manager will take updated photos of all current residents and place in personal file by 2/28/2023.	

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A 021	Continued From page 18 (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and	A 021		

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A 021	Continued From page 19 (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.21 A (5) (d) Based on record review and interview, the facility failed to ensure for 5 (R #s 2, and 5- 8) of 15 (R #s 1-15) whose records were reviewed for compliance, that there was a recent photograph of the resident was included in their resident file. This deficient practice could likely result in the residents to be at risk of harm, if residents receive the wrong care and services by the DCS	A 021		

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A 021	Continued From page 20 because there was no identifying photograph in the resident's file. The findings are: A. Record review of R #2's resident file (admission date [redacted]21), revealed it did not include a recent photograph of the resident. B. Record review of R #5's resident file (admission date [redacted]20), revealed it did not include a recent photograph of the resident. C. Record review of R #6's resident file (admission date [redacted]22), revealed it did not include a recent photograph of the resident. D. Record review of R #7's resident file (admission date [redacted]22), revealed it did not include a recent photograph of the resident. E. Record review of R #8's resident file (admission date [redacted]21), revealed it did not include a recent photograph of the resident. F. On 07/08/22 at 2:44 pm, during an interview with the Assistant Wellness Director, she confirmed that R #s 2, and 5-8 resident files did not include a recent photograph of the resident. G. On 07/18/22 at 10:52 am, during an interview at the exit conference with the Administrator, she confirmed that R #s 2 and 5-8 resident files did not include a recent photograph of the resident.	A 021		
A 023	7 NMAC 8.2.23 Pets PETS: Pets are permitted in a licensed facility, in accordance with the facility's rules.	A 023	A 023 7 NMAC 8.2.23 Pets 1.Facility Business office manager will collect all Pet vaccination records and documentation at time of residency agreement signing.	12/31/2022

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A 023	Continued From page 21 A. Prohibited areas. Animals are not permitted in food processing, preparation, storage, display and serving areas, or in equipment or utensil washing areas. Guide dogs for the blind and deaf and service animals for the handicapped shall be permitted in dining areas pursuant to Subsection K of 7.6.2.9 NMAC. B. Vaccination. Pets shall be vaccinated in accordance with all state and local requirements and records of such vaccination shall be kept on file in the facility. [7.8.2.23 NMAC - Rp, 7.8.2.24 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.23 B Based on record review and interview, the facility failed to ensure that all pets (dogs and cats) living in the facility had current vaccination records on file and available for review. This deficient practice could likely result in the 118 (R #s 1-118) residents listed on the census provided by the Administrator on 06/23/22, to be at risk of harm or illness, if the residents are bitten or contract communicable diseases from the animal that does not have current vaccinations. The findings are: A. Record review of vaccination records for the seven (7) pets living in the facility, revealed that: 1. Two (2) of the 7 pets residing in the facility did not have documentation of current vaccinations. 2. One (1) of the 7 pets residing in the facility had documentation that revealed the vaccines	A 023	2. Facility Business office manager will keep all pet vaccination records and documentation in residents financial file as well as in a separate Pet vaccination folder. 3. Facility Business Office Manager will send out reminders to residents when pet vaccinations need to be updated and collect proper documentation when pets receive required vaccinations. 4. All updated documentation for pet vaccinations has be acquired and placed in residents financial files as well Pet Vaccination Folder on 12/31/2023 by facility business office manager.	

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A 023	Continued From page 22 were expired. B. On 06/29/22 at 3:24 pm, during an interview with the Assistant Wellness Director, she confirmed that the vaccination records for 3 of the 7 pets living in the facility were not up-to-date. C. On 07/18/22 at 10:52 am, during an interview at the exit conference with the Administrator, she confirmed that the vaccination records for 3 of the 7 pets living in the facility were not up-to-date.	A 023		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be	A 026	A026 7 NMAC 8.2.26 Individual Service Plan 1.Assessment and ISP will be completed upon admission by facility Administrator or Director of Health and Wellness. After resident has physically moved in the facility Director of Health and Wellness will have a meeting with resident/POA to review ISP and assessment and sign off on services within 5 days of physical move in. The assessment will be re-evaluated every six months or upon change to residents needs and a new ISP will be created. 2.Each residents ISP will include who is responsible for providing services, how the services will be provided and expected goals and outcomes of the services provided. 3.A copy of each residents ISP and signed assessment will be kept in residents personal file as well as in a community binder accessible to direct care staff. 4.Each current residents ISP will be updated to include who is responsible for providing services, how the services will be provided and expected goals and outcomes of the services provided. This will be completed by 6/1/2023.	6/1/2023

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A 026	Continued From page 23 provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (2) (3) B (3) (5) (7) Based on record review and interview, the facility failed to ensure for 4 (R #s 1, 5, 6 & 8) of 4 (R #s 1, 5, 6, & 8) residents whose Individual Service Plans (ISP's) were reviewed for compliance, that they: 1. Were completed within 10 days of admission. 2. Were reviewed and updated at a minimum of every 6 months or when there was a significant change in the resident's health by a Licensed Practical Nurse (LPN), Registered Nurse (RN) or Physician Extender (PE). 3. Included who would provide services. 4. Included how services would be provided 5. Included expected goals and outcomes of the services. These deficient practices could likely to result in the residents not receiving appropriate	A 026		

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A 026	Continued From page 24 care/services if the Direct Care Staff (DCS) were not aware of: 1. What care and services the resident's needs. 2. If the ISPs are not current 3. Who will provide the care and services. 4. How the care and services are to be provided 5. What the resident's goals and outcomes are. The findings are: A. Record review of R #1's resident file, (admission date [redacted]19) revealed the following: 1. [redacted] dated [redacted]21, was not completed within 10-days after admission [redacted]19). 2. ISPs were not revised at a minimum of every 6 months as required by regulation. 3. No mention of who will provide services 4. How services would be provided 5. No expected goals and outcomes of the services B. Record review of R #5's resident file, (admission date [redacted]20) revealed the following: 1. There was no [redacted] completed within 10-days after admission [redacted]20) 2. [redacted] dated [redacted]/22 were not revised at a minimum of every 6 months as required by regulation. 3. No mention of who will provide services 4. How services would be provided 5. No expected goals and outcomes of the services C. Record review of R #6's resident file, (admission date [redacted]20) revealed the following: 1. No [redacted] was completed within 10-days after admission [redacted]/20). 2. [redacted] dated [redacted]/22 did not have the following: a. No mention of who will provide services	A 026		

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A 026	Continued From page 25 b. How services would be provided c. No expected goals and outcomes of the services D. Record review of R #8's resident file, (admission date [redacted]21) revealed the following: 1. No[redacted]was completed within 10-days after admission [redacted]21). 2. ISPs dated 04/14/22 were not revised at a minimum of every 6 months as required by regulation. 3. No mention of who will provide services 4. How services would be provided 5. No expected goals and outcomes of the services E. On 07/07/22 at 2:10 pm, during an interview with the Business Director, she confirmed that the ISPs/Assessment documents found in the resident files were the only documents regarded as ISPs even though they did not contain all the information required. F. On 07/18/22 at 10:52 am, during the exit interview with the Administrator, she confirmed the ISPs/Assessments on file did not include the required information for ISPs stated above.	A 026		
A 029	7 NMAC 8.2.29 Transportation TRANSPORTATION: The facility shall either provide transportation or assist the resident in using public transportation. A. The facility ' s motor vehicle transportation assistance program shall include the following elements: (1) resident evaluation; (2) staff training in hazardous driving conditions; (3) safe passenger transport and assistance;	A 029	A029 7 NMAC 8.2.29 Transportation 1.Facility Direct Care Staff who operate transportation vehicles will receive the appropriate training for operating and transporting residents by facility Administrator. Training to include. A. Hazardous driving conditions. B. Safe passenger transport assistance. C. Emergency procedures and use of equipment. D. Supervised practice in safe operation of motor vehicles, maintenance, and safety record keeping.	2/8/2023

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

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A 029	Continued From page 26 (4) emergency procedures and use of equipment; (5) supervised practice in the safe operation of motor vehicles, maintenance and safety record keeping; and (6) copies of employee training certificates that give evidence of successful completion of any applicable course(s) shall be kept on site in the employee files. B. To assist residents in using public transportation, the facility shall provide information on bus schedules, location of bus stops and telephone numbers of taxi cab companies. [7.8.2.29 NMAC - Rp, 7.8.2.30 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.29 A (2-6) Based on record review and interview, the facility failed to ensure that the DCS who transport residents had the required transportation training and received certificates of completion. This deficient practice could likely result in the 118 (R #s 1-118) residents identified on the census provided by the Administrator on 06/23/22, to be at risk of harm, injury, and/or death if they are being transported by DCS who do not know how to provide the proper methods of safe transportation and assistance. The findings are: A. Record review of DCS #20's (hire date 04/03/06) employee file, revealed no documentation of transportation trainings for: 1. Staff training in hazardous driving conditions. 2. Safe passenger transport and assistance.	A 029	2. Documentation of employee training certificates and evidence of successful completion of any applicable courses will be kept in staff's personal file. 3. Current staff records of completing required trainings and certificates have been updated as of 2/8/2023 and placed in staff's personal file by facility business office manager. A training binder for transportation with required trainings will be utilized ongoing.	

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A 029	Continued From page 27 3. Emergency procedures and use of equipment. 4. Supervised practice in the safe operation of motor vehicles, maintenance and safety record keeping. 5. Copies of employee training certificates that give evidence of successful completion of any applicable course(s). B. Record review of DCS #21's (hire date 11/23/19) employee file, revealed no documentation of transportation trainings for: 1. Staff training in hazardous driving conditions. 2. Safe passenger transport and assistance. 3. Emergency procedures and use of equipment. 4. Supervised practice in the safe operation of motor vehicles, maintenance and safety record keeping. 5. Copies of employee training certificates that give evidence of successful completion of any applicable course(s). C. On 06/30/22 at 2:20 pm, during an interview with the Business Manager, she confirmed that DCS #s 20 and 21 had not completed the required trainings or are certified to transport residents. D. On 07/08/22 at 2:44 pm, during an interview with the Assistant Wellness Director, she confirmed that DCS #s 20 and 21 had not completed the required trainings or are certified to transport residents. E. On 07/18/22 at 10:52 am, during an interview with the Administrator at the exit conference, she confirmed that DCS #s 20 and 21 had not completed the required trainings or are certified to transport residents.	A 029		

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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 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: 7.8.2.32 A (1) B	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 properly 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. 5. 5. Documentation of training on incident reporting will be kept in Directors personal file.	4/1/2023

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A 032	Continued From page 29 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W, 8 B (2), 10 C W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. C. All licensed health care facilities shall conduct a complete investigation and report the actions taken and conclusions reached by the facility	A 032		

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A 032	Continued From page 30 within five (5) days of discovery of the incident. Based on record review, observation, and interview, the facility failed to ensure for 2 (R #s 10, and 20) of 2 (R #s 10, and 20) whose residents files and Incident Reports were reviewed for compliance, that incidents of possible abuse, neglect, injuries of unknown origin, events including but not limited to falls which cause injury, 1. Were reported to the Licensing Authority within 24 hours or the next business day, if it is a weekend or a holiday. 2. That an internal investigation was completed and a follow-up investigation report was submitted within five (5) business days from the date the incident occurred. This deficient practice could likely result in the residents to be at risk of harm, injury, and/or death, if incidents occur and there is no oversight by the Licensing Authority. The findings are: Findings for R #10 A. On 06/27/22 at 9:35 am, during observation of the MCU, R #10 was observed in bed with [redacted] B. On 06/28/22 at 11:00 am, during an interview with R #10's Power of Attorney (POA), [redacted] stated that R #10 had 2 previous falls from [redacted] bed, an incident of a [redacted] of unknown origin, and this last fall that rendered [redacted] stated that the incidents were reported to [redacted] by the facility. C. Record review of an Internal Incident Report	A 032		

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A 032	Continued From page 31 dated 06/15/22, revealed that at 2:30 pm, R #10 was found with a [redacted] (Injury of unknown origin). R #10 was given [redacted] pain medication). POA and Hospice were called on 06/15/22 and the Administrator was notified. Resident placed on 20 minute status checks. D. Record review of an Internal Incident Report dated 06/20/22, revealed that at 11:20 pm, R #10 had an unwitnessed fall with injury [redacted] and was found on the hallway floor with a [redacted] Staff assisted her into her wheelchair and call the hospice nurse to check on resident. PRN sedative medication. Resident needs reevaluation so she can received 1 on 1 care to prevent these kinds of falls from happening again. E. Record review of R #10's resident file revealed, no documentation that the incidents listed above: 1. Were reported to the Licensing Authority within 24 hours or the next business day, if a holiday or weekend. 2. That an internal investigation was conducted and/or that an investigation follow-up report was submitted to the Licensing Authority within 5-business days from the date of the incident. F. On 07/18/22 at 10:52 am, during the exit interview with the Administrator, she confirmed that incidents listed above for R #10: 1. Were not reported to the Licensing Authority within 24 hours or the next business day if a holiday or weekend. 2. That an internal investigation was not conducted and/or that an investigation follow-up report was not submitted to the Licensing Authority within 5-business days from the date of	A 032		

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A 032	Continued From page 32 the incident. Findings for R #20 G. On 07/19/22 at 1:48 pm, during an interview with DCS #22, she stated that R #20 had fallen near the dining room and it took more than 30 minutes for [redacted] get help from caregivers. H. Record review of requested documents for R #20 and received on 07/21/22 at 12:49 pm, via email from DCS #8, revealed the following resident falls: 1. Internal Incident Report dated 06/11/22, stated that on 06/11/22 at 6:34 am, R #20 had an unwitnessed fall with injury [redacted] outside the facility, Emergency Medical Services were called, and was treated at the hospital. (There was no hospital follow-up on outcome). 2. Internal Incident Report dated 06/11/22, stated that on 06/11/22 at 1:06 pm, R #20 had an unwitnessed fall with injury [redacted] in [redacted] room and was treated at the hospital (There was no hospital follow-up on outcome). 3. Internal Incident Report dated 06/12/22 at 4:00 am, R #20 had an unwitnessed fall (without injury), found by staff, resident was sleeping on last 30-minute check. 4. Internal Incident Report dated 06/12/22 at 4:30 am, R #20 had an unwitnessed fall (without injury), found by another resident, resident had been checked on 30-minutes prior, did not complain of pain, upset about falling. Resident was assisted off floor and back bed. 30-minute-1 hour status checks with continue. 5. Internal Incident Report dated 06/12/22 at 1:06 pm, R #20 had an unwitnessed fall with injury [redacted] POA and EMS contacted and resident was sent	A 032		

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A 032	Continued From page 33 out to the hospital. Resident referred to Memory Care Unit. I. On 07/21/22 at 1:59 pm, during an interview with R #20's Power of Attorney (POA) he stated that R #20 had 2 falls that [redacted] remembered on the same weekend before the one that took [redacted] to the hospital on 06/12/22. [redacted] stated that R #20 had become a wanderer and unable to stay in the Assisted Living unit, the family decided to move [redacted] to MCU, and the resident is now on Hospice. J. On 09/07/22 at 10:41 am, during an interview with the Administrator, she confirmed that the following incidents for R #20: 1. Were not reported to the Licensing Authority within 24 hours or by the next business day. 2: Internal investigations were not completed and 5-day follow-up reports were not submitted to the Licensing Authority within 5 business days from when the incidents occurred.	A 032		
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	A 034	A 034 7 NMAC 8.2.34 Custodial Drug Permits 1.Facility Administrator and Direct Care staff will ensure that all oxygen tanks located in the oxygen room are secured in proper storage containers in accordance with (NFPA) 99. 2.Facility Direct Care Staff will ensure that residents in need of portable oxygen tanks will have a limit of one tank available in apt and that the tank is secure in a proper storage containers in accordance with (NFPA) 99. 3.Facility Administrator will complete in service with Direct Care staff on how to properly store and secure oxygen tanks in accordance with (NFPA) 99. Record of In service will be kept in direct care staff's personal file.	3/31/2023

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A 034	Continued From page 34 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. (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;	A 034		

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A 034	Continued From page 35 (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 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	A 034		

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A 034	Continued From page 36 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 (7) Refer to: NFPA (National Fire Prevention Association) 99. 2012 Edition. 11.3 Cylinder and Container Storage Requirements. 11.3.1* Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. 11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. 11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible	A 034		

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A 034	Continued From page 37 construction having a minimum fire protection rating of 1/2 hour 11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations. 11.3.2.8 Cylinder valve protection caps shall comply with 11.6.2.3. 11.3.2.9 Gas cylinder and liquefied gas container storage shall comply with 5.1.3.5.12. 11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 11.3.3.1 and 11.3.3.2. 11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not be required to be stored in enclosures. 11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. 11.3.3.3 When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders. 11.3.3.4 Individual small-size (A, B, D, or E) cylinders available for immediate use in patient care areas shall not be considered to be in storage. 11.3.3.5 Cylinders shall not be chained to portable or movable apparatus such as beds and oxygen tents. 11.3.4 Signs.	A 034		

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A 034	Continued From page 38 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following wording as a minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN (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. Based on record review, observation, and interview, the facility failed to ensure that Oxygen cylinder tanks were stored securely and protected from accidental damage or dislocation. These deficient practices could likely result in the 118 (R #s 1-118) residents listed on the resident census, provided by the Administrator 06/23/22, to be at risk of harm, injury, or death if oxygen cylinder tanks were to fall over damaging the valve, causing them to depressurize during a fire, the oxygen feeds the fire, causing it to spread faster and/or the cylinder tanks act like missiles and hit a resident/staff/rescuer during a fire. The findings are: Findings for oxygen in storage room A. On 06/23/22 at 2:31 pm, during observation of the oxygen storage room (3rd floor assisted living unit) the following oxygen cylinders were observed to be unsecured: 1. Three (3) short cylinder tanks 2. Six (6) small cylinder tanks 3. Four (4) large cylinder tanks B. On 06/27/22 at 9:32 am, during observation in	A 034		

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A 034	Continued From page 39 the Memory Care Unit (MCU), resident room #110, 2 large unsecured oxygen cylinders were observed in the closet. C. On 06/27/22 at 9:32 am, during an interview, DCS #10 confirmed that there were 2 unsecured oxygen cylinders in the closet of resident room #110. D. On 06/30/22 at 10:42 am, during observation of R #1's room, 2 unsecured oxygen cylinders were observed in the hallway to the apartment bathroom. E. On 07/08/22 at 2:44 pm, during an interview, the Assistant Wellness Director confirmed all the oxygen cylinder tank findings listed above. F. On 07/18/22 at 10:52 am, during an interview with the Administrator, she confirmed all the oxygen cylinder tank and medication findings listed above.	A 034		
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.	A 035	A 035 7 NMAC 8.2.35 Medication 1. Facility Direct Care Staff will update all resident MARs to include resident diagnosis/reason for medications and / or both the brand and generic names of medications. 2. Facility Medication carts will have all medications labeled and dated correctly in accordance with 7 NMAC 8.2.35 by Facility Direct Care Staff. 3. Facility Administrator will conduct a retraining with all Medication Aides on 3/1/2023 to ensure that all Medication Aides are following 7 NMAC 8.2.35 and NM Assisting with Medication guidelines. Documentation of this training will be kept in Direct Care staffs personal file.	6/01/2023

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A 035	Continued From page 40 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 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.	A 035		

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A 035	Continued From page 41 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 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;	A 035		

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A 035	Continued From page 42 (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (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	A 035		

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A 035	Continued From page 43 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] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (4, 5, 16) Based on record review and interview, the facility failed to ensure for 5 (R #s 1, 2, 3, 5 and 6) of 5 (R #s 1, 2, 3, 5 & 6) residents whose Medication Assistance Records (MARs) were reviewed for compliance were accurate, complete, and included all required information. These deficient practices could likely result in the residents to be at risk of harm, if the DCSAM: 1. Do not understand what the medication is being given for, because diagnosis/reason for the medication was not listed. 2. Do not recognize the name of the medication, if both brand name and generic name are not listed. 3. Do not know if a medication is missed, and/or extra dose is administered in error, because it was not initialed by the DCSAM. The findings are: Findings for R #1 are: A. Record review of R #1's April, May, and June, 2022 MARs, revealed that the following listed medications did not include the diagnosis/reason for medications and/or both the brand/generic	A 035		

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A 035	Continued From page 44 names: [redacted]	A 035		

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A 035	Continued From page 45 [redacted]	A 035		

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A 035	Continued From page 46 [redacted] B. Record review of R #1's April and May, 2022 MARs, revealed the following medications were not initaled by staff when given (left blank) and there was no documentation/reason noted as to why on the MAR: 1. April 2022 MAR revealed that [redacted] 04/01/22-04/02/22, 8:00 am, 2:00 pm, and 8:00 pm doses were not initialed as given and there was no reason as to why noted on the MAR. 2. May 2022 MAR revealed that [redacted] 05/05/22 2:00 pm dose was not initaled as given and there was no documentation why. Findings for R #2:	A 035		

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A 035	Continued From page 47 C. Record review of R #2's April, May, and June, 2022 MARs, revealed the following listed medications did not include the diagnosis/reason for medications and/or both the brand/generic names: 1. April 2022 MAR: [redacted]	A 035		

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A 035	Continued From page 48 [redacted]	A 035		

D. Record review of R #2's April, May, and June, 2022 MARs, revealed that they did not included both the brand/generic names for Naloxone.

Findings for R #3:

E. Record review of R #3's March, 2022 MAR, revealed that following listed medications did not include the diagnosis/reason for medications and/or both the brand/generic names: [redacted]

F. Record review of R #3's March, 2022 MAR revealed that it did not include both brand/generic name for Celecoxib 50 mg.
Findings for R #5:

Findings for R #5

G. Record review of R #5's March, April, May, and June, 2022 MARs revealed, the following medications did not include the diagnosis/reason for medications and/or both the brand/generic names:
1. March 2022 MAR: [redacted]

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A 035	Continued From page 49 [redacted]	A 035		

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A 035	Continued From page 50	A 035		

[redacted]

H. Record review of R #5's March, 2022 MAR, revealed the following 8:00 pm, doses of medication were not initaled as given by DCSAM on 03/31/22:

[redacted]

Findings for R #6:

I. Record review of R #6's April, May, and June, 2022 MARs, revealed that the following listed medications did not include the diagnosis/reason for medications and/or both the brand/generic names:

1. April 2022 MAR:

[redacted]

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A 035	Continued From page 51 [redacted]	A 035		

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A 035	Continued From page 52 [redacted] J. Record review of R #6's April, May, and June, 2022 MARs revealed, that they did not included both the brand/generic names for the following medications: [redacted] K. On 07/18/22 at 10:52 am, during an interview with the Administrator, she confirmed the MAR findings for R #s 1, 2, 3, 5 & 6 listed above.	A 035		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the	A 036	A 036 7 NMAC 8.2.36 Nutrition 1. A 036 4a Facility Director of Dietary will ensure that all garbage receptacle's in the kitchen will have close fitting covers and trash will be disposed of properly between shifts. New lids have been ordered for the garbage receptacles in the kitchen and old lids with the holes have been disposed of. 2. A 036 4aD2a Facility will Director of Dietary ensure that temperature logs are kept for each freezer and refrigerator. Dietary staff will monitor the temperature of both daily and a log will kept in a visible location. Staff will notify Dietary Director of any changes to the temperature of either item. Dietary staff will clean out freezers and refrigerators weekly to ensure that they are kept sanitary weekly.	3/1/2023

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A 036	Continued From page 53 premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage;	A 036	3. A 036 4aD3 Dietary Director will retrain all staff on the importance of labeling all perishable items and the proper storage of perishable items. Any food items that are not at correct temperature or properly dated will be discarded immediately. 4. Dietary Director will instruct staff to clean the kitchen walls and floors weekly as well as when needed. All dirty rags are to be kept in dirty linen container. 5. Water tank in Memory Care unit has been replaced with a new water tank. Direct care staff will clean water tank weekly. 6. The drinking stations in both main dining room as well as Memory Care dining room have been cleaned. Both are on a weekly schedule to be cleaned with log kept on machine. Director of Dietary will monitor logs monthly.	

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A 036	Continued From page 54 (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall	A 036		

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A 036	Continued From page 55 be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and	A 036		

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A 036	Continued From page 56 a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water	A 036		

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A 036	Continued From page 57 back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.36 B 4 C 1 (a, c) 4 D 3 (a) (3) 8 (a) Based on record review, observation, and	A 036		

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A 036	Continued From page 58 interview, the facility failed to ensure that: 1. A daily log of the recorded temperatures for all facility refrigerators, freezers, and steam tables maintained and available for inspection for thirty (30) calendar days. 2. Kitchen and equipment where food is prepared are kept clean and sanitary. 3. All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. 4. The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees Fahrenheit and all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees Fahrenheit. 5. Refrigerators and freezers shall be kept clean and sanitary at all times. 6. Food stored in refrigerators and freezers were covered, dated, and labeled and any unused leftover foods were discarded after three (3) calendar days. These deficient practices could likely result in the 118 (R #s 1 - 118) listed on the census provided by the Administrator on 06/23/22, to be at risk of harm from contracting foodborne illnesses caused by bacteria if: 1. There is no documentation that food storage, refrigeration, and food cooking/preparation areas are maintained in a clean, temperature controlled, safe and sanitary condition. 2. Residents were to ingest food that was contaminated with germs, bacteria, and mold, located where food is prepared and the area is not kept clean and sanitary. 3. Food becomes contaminated with germs and bacteria, because some of the trash can lids have large holes cut out in them, and some of	A 036		

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A 036	Continued From page 59 them do not have lids. 4. Residents were to ingest perishable food that is not refrigerated and maintained at a temperature no higher than forty-one (41) degrees Fahrenheit. 5. There is no documentation that food storage, refrigeration, and food cooking/preparation areas are maintained in a clean, temperature controlled, safe and sanitary condition. 6. Food, was not stored properly (dated, labeled), and leftovers were kept longer than (3) three days after being served the 1st time. The findings are: A. On 06/23/22 at 1:14 pm, during an observation of the kitchenette adjacent to the main dining room, it was observed that the trash can lid was missing. B. On 06/23/22 at 1:16 pm, during an observation of the main kitchen, it was observed that: 1. The trash can located in Cook #1's kitchen office was overflowing, with trash on the floor, and the trash can had no lid on it. 2. A large bag of rags was laying on the grimy and sticky floor in Cook #1's kitchen office. C. On 06/23/22 at 1:24 pm, during an observation of the main kitchen, it was observed that: 1. Two (2) large kitchen trash cans had lids with large, circular cutout openings in them. 2. Walls and floors in the kitchen and cook's adjacent office were filthy. 3. Refrigerator temperature was too high: a. Internal temperature was at 53 degrees Fahrenheit b. Observed meat stored in the refrigerator was	A 036		

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A 036	Continued From page 60 bleeding out because it was warm. D. On 06/27/22 at 9:27 am, during an observation of the MCU kitchenette and dining area, it was observed that the: 1. Trash can had no lid on it. 2. Freezer was dirty and contained a cup of ice cream with a spoon inside, and it was not covered or labeled. 3. The beverage dispenser table was grimy and had a yellowish liquid substance that contained green and black mold in it. 4. There were no thermometers in the refrigerator or freezer. 5. There were no temperature logs for the refrigerator or freezer. E. On 06/27/22 at 9:45 am, during an observation of the MCU activity area, it was observed that: 1. A self-serve water tank was wobbly and did not fit on the dispenser properly because it did not contain a seal. 2. The empty water tank was removed from the dispenser, and it contained standing water that was contaminated. 3. The water dispenser drain area was dirty. F. On 06/23/22 at 1:14 pm, during an interview, Cook #3 confirmed that the kitchenette adjacent to the main dining room had a trash can with the lid missing. G. On 06/23/22 at 1:16 pm, during an interview, Cook #1 confirmed that: 1. The trash can located in his kitchen office was overflowing, with trash on the floor, and the trash can had no lid on it. 2. A large bag of rags was laying on the grimy and sticky floor in Cook #1's kitchen office.	A 036		

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A 036	Continued From page 61 H. On 06/23/22 at 1:24 pm, during an interview, Cook #1 confirmed that: 1. Two large kitchen trash cans had lids with circular cutout openings in them. 2. The walls and floors in the kitchen were filthy. 3. The refrigerator temperature was too high as follows: a. The internal temperature was at 53 degrees Fahrenheit b. Meat stored in the refrigerator was bleeding out because it was warm. I. On 06/27/22 at 9:27 am, during an interview, DCS #10 confirmed that in the MCU kitchenette area: 1. The trash can had no lid on it. 2. The freezer was dirty and contained a cup of ice cream with a spoon inside was not covered or labeled. 3. The beverage dispenser table was grimy and had a yellowish liquid substance on it that contained green and black mold in it. 4. There were no temperature logs for the refrigerator or freezer. J. On 06/27/22 at 9:45 am, during an interview, DCS #8 confirmed that in the MCU activity area: 1. A self-serve water tank was wobbly and did not fit properly on the dispenser because it did not contain a seal. 2. The empty water tank was removed from the dispenser, and it contained standing water that was contaminated. 3. The water dispenser drain area was dirty. K. On 06/27/22 at 1:37 pm, during an interview, then Administrator confirmed that: 1. The MCU kitchenette beverage dispenser table was grimy and had a yellowish liquid	A 036		

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A 036	Continued From page 62 substance on it that contained green and black mold in it. 2. The MCU refrigerator and freezer did not have a temperature log available. L. On 07/08/22 at 2:44 pm, during an interview with, the Assistant Wellness director, she confirmed that the: 1. Main kitchen refrigerator temperature was too high and contained meat that was bleeding out. 2. Main kitchen and all kitchenettes have trash cans with no lids and some trash cans with lids that have large circular holes cut out on top. 3. Main kitchen was dirty, floors were grimy and sticky, walls were dirty, and the kitchen's overall appearance was dirty. 4. MCU kitchenette refrigerator and freezer were: a. Dirty and unsanitary. b. Contained no internal thermometers c. Had no temperature logs. 5. The MCU kitchenette beverage dispenser table was grimy and had a yellowish liquid substance on it that contained green and black mold in it. M. On 07/18/22 at 10:52 am, during an interview with the Administrator at the exit conference she confirmed that the: 1. Main kitchen refrigerator temperature was too high and contained meat that was bleeding out. 2. Main kitchen and all kitchenettes have trash cans with no lids on them and some trash cans with lids that have large circular holes cut out on top. 3. Main kitchen was dirty, floors were grimy and sticky, walls were dirty, and the kitchen's overall appearance was dirty. 4. MCU kitchenette refrigerator and freezer were: a. Dirty and unsanitary. b. Contained no internal thermometers.	A 036		

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A 036	Continued From page 63 c. Had no temperature logs. 5. MCU kitchenette beverage dispenser table was grimy and had a yellowish liquid substance on it that contained green and black mold in it.	A 036		
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 A C Based on observation and interview, the facility	A 038	A 038 7 NMAC 8.2.38 Housekeeping Services 1.Facility Adminsitrator will send out a memo to all residents reminding them that all trash and personal laundry must be kept in apartment until it is picked up by the housekeeping department. Trash and personal laundry will not be left outside of residents apartments to be picked up by housekeeping. 2. The Carpet in Memory Care will be shampooed monthly by facility maintenance staff. Memory care housekeeper will ensure that flooring and overall common areas are cleaned daily sanitized and deodorized. 3. All trash receptacles will have proper fitting lids and trash will be disposed of during each shift. Direct care staff will dispose of trash during each shift from all common areas. Direct care staff will remove trash from residents apartments daily. 4. Beverage station in Memory Care Kitchen will be cleaned weekly and log will be kept on Machine by direct care staff. 5. All cleaning products and chemicals will be properly labeled and stored in safe and secured location. Director of housekeeping will have an in-service to review proper labeling and storage of all chemicals. Direct care staff will check residents apartments weekly for chemicals that need to be removed and stored in proper location. 6. Facility maintenance staff repaired leaking toilet in womans restroom on the 2nd floor by southeast side of dinning room. Housekeeping staff will report any plumbing issues to Maintenance staff. 7. Facility direct care staff will report any findings of rodents and or bugs to the maintenance director. Maintenance Director will have all areas with any bug or rodent problems sprayed weekly by local pest control until problem is resolved. Log of pest control	3/1/2023

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A 038	Continued From page 64 failed to ensure that: 1. The interior of the facility was maintained in a clean, safe, clean, sanitary/attractive manner and was free from offensive odors, safety hazards, and insects. 2. That flammable/poisonous substances were stored in secure areas, and not accessible to residents. These deficient practices could likely result in the the 118 (R #'s 1 - 118) residents listed on the resident census list provided by the Administrator on 06/23/22, to be at risk of harm, injury, or death if residents were bitten by insects, get ill from diseases caused by crawling bugs (roaches), or ingest or spill poisonous cleaning chemicals on themselves. The findings are: A. On 06/23/22 at 1:00 pm, during observation of the kitchenette by the dining room on the Northside was observed to have an open trash can containing trash while food was being served from the area. B. On 06/23/22 at 1:10 pm, during an interview with Cook #3, he confirmed that the trash can did not have a lid. C. On 06/23/22 at 1:16 pm, during observation of the kitchen, the following was observed: 1. The lids of all 4 large trash cans had been cut open exposing the garbage. 2. The food cart used to transport food from the kitchen to dining room was dirty. 3. The kitchen floors were sticky and dirty 4. A small uncovered trash can in the chef's office was overflowing with trash.	A 038	visits will be kept at Facility front desk for review. Log will include apt numbers and date of pest control visit.	

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A 038	Continued From page 65 D. On 06/23/22 at 1:16 pm, during an interview with both Cook #s 1 and 2 , they confirmed the above listed kitchen findings. E. On 06/23/22 at 2:34 pm, during observation of the hallway the following was observed: 1. An uncovered laundry basket containing dirty laundry outside room #359. 2. A dirty toilet seat was leaning in the corner. F. On 06/27/22 at 9:00 am, during observation in the Memory Care Unit (MCU), the following was observed, The: 1. Carpet in the reception area was dirty with large stains. 2. Carpet in the hallway on the South side of the building was dirty, spotted with what looked like food/drink spills, and urine smell stains. 3. Entire MCU had an offensive odor. 4. Beverage machine was leaking and appeared to have black and green mold on it. 5. Floors in the kitchen were dirty 6. Trash can in the kitchenette had no lid G. On 06/27/22 at 9:20 am, during an interview, DCS #10 confirmed the observations listed above. H. On 06/27/22 at 9:39 am, during observation in resident room #111, the following was observed: 1. One (1) Multi-Surface disinfectant cleaner - 23 oz fl. 2. One (1) All-purpose cleaner - 22 oz fl. 3. One (1) Multipurpose cleaner 32 oz fl. 4. The bathroom floor was dirty and sticky to walk on. 5. The open trash can was full of dirty adult diapers.	A 038		

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A 038	Continued From page 66 I. On 06/27/22 at 9:39 am, during an interview, DCS #10 confirmed that the 3 chemicals were found in resident room #111's bathroom, the bathroom floor was dirty, and the open trash can had used adult diapers. J. On 06/27/22 at 9:45 am, during observation of the MCU activity room, a water dispensing machine was found in the corner had an empty water bottle that was halfway fitting into the machine and had no ring to hold the bottle, exposing uncovered stagnant water that could be accessed by residents. K. On 06/27/22 at 9:45 am, during an interview, DCS #10 confirmed the water machine findings above. L. On 06/28/22 at 11:00 am, during an interview with R #10's Power of Attorney (POA), she stated that R #10's room was always dirty when they visited on weekends, used adult diapers overflowing from trash can were on the floor, and the bathroom floor and toilet dirty. M. On 06/29/22 at 10:10 am, during observation of the bathroom in the hallway on the Southeast side of the dining room, the following was observed: 1. The middle stall of the 3 stalls was leaking and there was a foul smell in the bathroom. 2. There was a hole in the wall behind one of the toilets stuffed with paper. N. On 06/29/22 at 10:15 am, during an interview, the Maintenance Director confirmed the bathroom findings listed above. O. On 06/30/22 at 10:35 pm, during an interview with (2 Direct Staff), DCS #24 stated that some	A 038		

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A 038	Continued From page 67 resident rooms are infested with roaches. P. On 07/06/22 at 1:25 pm, during an interview with R #8's Power of Attorney (POA) and R #8, they stated that: 1. R #8's room was infested with roaches that crawl on the walls at night. 2. A roach landed on R #8's face and [redacted] was unable to swat it away because of [redacted] Q. On 07/13/22 at 1:10 pm, during an interview with DCS #15, she confirmed that: 1. R #8's room and the kitchen were infested, that she complained about it many times, but the facility ignored it. 2. R #8's room had one of the worst roach infestations. 3. Another resident [redacted] on the 3rd floor's room was so unsanitary and infested, that there were baby roaches in [redacted] bed that [redacted] thought were bed bugs. R. On 07/18/22 at 9:50 am, during an interview with DCS #19, she confirmed that some resident rooms especially on the ground floors were infested with roaches, and that R #8 is always calling management about them. S. On 07/18/22 at 10:52 am, during an interview with the Administrator at the exit conference, she confirmed the roach findings listed above.	A 038		
A 047	7 NMAC 8.2.47 Lighting and Lighting Fixtures LIGHTING AND LIGHTING FIXTURES: A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area	A 047	A 047 7 NMAC 8.2.47 Lighting and Lighting Fixtures 1.Facility maintenance Director repaired apt 105 bathroom light fixture on 7/10/2022. 2.Facility Maintenance Director ordered 4 replacement lights for the Main Kitchen to remove existing lights that are missing the covers on 2/7/2023. Lights will be installed in kitchen 2/28/2023.	3/1/2023

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A 047	Continued From page 68 clearly visible. B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting. C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the residents, with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering. E. Facilities with four (4) or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service. F. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7.8.2.47 NMAC - Rp, 7.8.2.48 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.47 A, D Based on observation and interview the facility failed to ensure that: 1. All lighting fixtures have protective covers. 2. All light fixtures were in working order. These deficient practices have the potential for all 118 (R #1 - 118) residents listed on the census, provided by the Administrator on 06/23/22, to be at risk of harm, injury, or death if: 1. The light bulbs fall or break and there are no protective covers on the lighting fixtures that	A 047	3. Facility Maintenance Director will ensure that all light fixtures in community are working properly and replace/repair as needed.	

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A 047	Continued From page 69	A 047		

protect residents from broken glass or falling light bulbs.
2. Residents are at risk of harm or injury if they cannot see where they are going, and potentially causing them to fall.

The findings are:

A. On 06/23/22 at 1:24 pm, during observation of kitchen, it was observed that four (4) ceiling light fixtures were broken or missing covers.

B. On 06/27/22 at 9:16 am, during a tour of the MCU, it was observed that room #105 bathroom light fixture was not working.

C. On 07/08/22 at 11:29 am, during an interview with the Maintenance Director, he stated that the 4 ceiling light fixture covers had not been replaced because the fixtures are old and the covers aren't made anymore.

D. On 06/23/22 at 1:24 pm, Cook #1 confirmed that 4 ceiling light fixtures were broken or missing.

E. On 06/27/22 at 9:16 am, DCS #10 confirmed that room #105 bathroom light fixture was not working.

F. On 07/08/22 at 11:29 am, the Maintenance Director confirmed that:
1. Four kitchen ceiling light fixture covers were broken or missing.
2. The bathroom light in room# 105 bathroom was not working.

G. On 07/08/22 at 2:44 pm, during a meeting with the Assistant Wellness Director , she confirmed that:

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A 047	Continued From page 70 1. Four kitchen ceiling light fixture covers were broken or missing. 2. The bathroom light in R #12's bathroom was not working. H. On 07/18/22 at 10:52 am, during the exit conference via telephone, surveyors informed the Administrator about the findings and she confirmed that: 1. Four kitchen ceiling light fixture covers were broken or missing. 2. The bathroom light in R #12's bathroom was not working.	A 047		
A 059	7 NMAC 8.2.59 Windows WINDOWS: A. Each sleeping room shall be provided with an exterior window. (1) The window shall be operable, screened and have a clear operable area of 5.7 square feet minimum; measured twenty (20) inches wide minimum and measured twenty-four (24) inches high minimum. (2) The top of the window sill shall not be more than forty-four (44) inches above the finished floor. B. Screens shall be provided on all operable windows. C. The proposed use of bars, grilles, grates or similar devices shall be reviewed and approved by the licensing authority prior to installation. D. Sleeping rooms, living rooms, activity room areas and dining room areas shall have a window area of at least one tenth (1/10) of the floor area with a minimum of ten (10) square feet. [7.8.2.59 NMAC - Rp, 7.8.2.52 NMAC, 01/15/2010]	A 059	A 059 7 NMAC 8.2.59 Windows 1.Facilty Director of Maintenance will repair and replace all window screens that are damaged. Maintenance director will also have maintenance staff check window screens upon apartment turns for any tears and or damage so they may be replaced at that time as well. 2. Facility Director of Maintenance will ensure that all window screens are replaced as needed going further. Weekly walks through the exterior of the community to check all screens will also be completed. Any screens showing damage or tears will be replaced at that time.	4/1/2023

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A 059	Continued From page 71 This REQUIREMENT is not met as evidenced by: 7.8.2.59 B Based on observation and interview the facility failed to ensure that all of the facility's windows had screens that were not torn and/or falling apart. This deficient practice could likely result in the 118 (R #s 1-118) residents identified on the resident census provided by the Administrator on 06/23/22, to be at risk of injury or illness due to bug bites or allergens because the screens on windows had holes in them. The findings are: A. On 07/30/22 at 7:30 am, during observation, resident room #110 was observed to have a window screen that had holes in it. B. On 07/07/22 at 3:04 pm, during observation, resident room #224 was observed to have a window screen that had holes in it. C. On 07/08/22 at 10:59 am, during an interview with the Maintenance Director, he confirmed that room #'s 110 and #224 had a window screens with holes in them. D. On 07/18/22 at 10:52 am, during an interview with the Administrator at the exit meeting, she confirmed the window screen findings listed above.	A 059		
A 066	7 NMAC 8.2.66 Staff and Resident Fire and Safety Training	A 066	A 066 7 NMAC 8.2.66 Staff and Resident Fire and Safety Training	3/1/2023

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A 066	Continued From page 72 STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff of the facility shall know the location and the proper use of fire extinguishers and the other procedures to be followed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff shall be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident admitted to the facility shall be given an orientation tour of the facility to include the location of the exits, fire extinguishers and telephones and shall be instructed in the actions to be taken in case of fire or other emergencies. D. Fire drill procedures. The facility must conduct at least one (1) fire drill each month. (1) Fire drills shall be held at different times of the day, evening and night. (2) The fire alarm system or detector system in the facility shall be used in the fire drills. During the night, the fire drill alarm may be silenced. (3) During the fire drills, emphasis shall be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall show the date and time of the drill, the number of personnel participating in the drill, any problem(s) noted during the drill and the evacuation time in total minutes.	A 066	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 Maintenance Director will ask local fire department to participate in a fire and safety evacuation drill. 4.Facility's Maintenance Director will have an orientation on Fire safety and evacuation process with each current resident. Record of this will be kept in residents personal file. this will be completed by 4/1/2023	

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A 066	Continued From page 73 (5) The local fire department may be requested to supervise and participate in the fire drills. [7.8.2.66 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.66 A C Based on record review and interview, the facility failed to ensure that: 1. All staff were trained in fire Safety/Evacuation. 2. The residents and/or their guardian/family member(s) received fire safety and evacuation orientation upon admission to the facility. This deficient practice could likely result in the 118 (R#'s 1 - 118) residents and staff listed on the census provided by the Administrator on 06/23/22, to be at risk of harm, injury, or death if a fire or other emergency were to occur because Direct Care Staff (DCSs) and residents do not know where the fire safety equipment is, the evacuation route, and/or where the exits are. The findings are: A. Record review of R #s 1-15 resident files, revealed no documentation that the resident or their guardian/family member(s) received Fire Safety and Evacuation orientation upon admission to the facility. B. On 06/30/22 at 8:40 am during an interview with the Maintenance Director (Fire Evacuation process Trainer), he stated that the monthly fire drills: 1. Were only performed with regular staff	A 066		

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A 066	Continued From page 74 members. 2. That temporary workers from agencies had not been trained. 3. Did not include the residents. C. On 06/30/22 at 10:30 pm during an interview with DCS #'s 24, 25, and 26, they stated that they had not been trained in fire safety and did not believe they would be able to evacuate all residents to safety if a fire was to break out. During the interview with the 3 DCSs, they were not aware of where the fire panel was located. D. On 07/08/22 at 12:00 pm, during an interview with the Business Manager, she stated that no fire drills had been performed while she was at work since she started working at the facility (Hire date 06/03/16) E. On 07/08/22 at 2:44 pm, during an interview with the Assistant Wellness Director, she confirmed the Fire Safety and Evacuation findings listed above. F. On 07/18/22 at 10:52 am, during an interview with the Administrator, during the exit meeting, she confirmed the Fire Safety and Evacuation findings listed above.	A 066		
A 067	7 NMAC 8.2.67 Smoking SMOKING: A. Smoking by residents and staff shall take place only in supervised areas designated by the facility and approved by the state fire marshal or local fire prevention authorities. Smoking shall not be allowed in a kitchen or food preparation area. B. All designated smoking areas shall be provided with suitable ashtrays that are not made	A 067	A 067 7 NMAC 8.2.67 Smoking 1.Facility Administrator will re-educate staff and residents on where the appropriate smoking areas are located and where to dispose of cigarette butts safely. New signage has been placed in smoking areas and none smoking areas 2/24/2023.	3/1/2023

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A 067	Continued From page 75 of combustible material. C. Residents shall not be permitted to smoke in bed. D. Smoking shall not be permitted where oxygen is in use, is present or is stored. [7.8.2.67 NMAC - Rp, 7.8.2.64 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.67 A B Based on observation and interview, the facility failed to ensure that there was a designated smoking area with suitable noncombustible ash trays where residents/staff could smoke and dispose cigarette butts safely. This deficient practice could likely result in the 118 (R #s 1 - 118) residents identified on the census provided by Administrator on 06/23/22, to be at risk of harm or death if a fire were to occur because there were no suitable non-combustible ashtrays to safely dispose of the cigarette butts. The findings are: A. On 07/07/22 at 11:13 am, during observation, two planter pots near the front entrance of the facility were observed to contain cigarette butts and there were no designated ashtrays. B. On 07/08/22 at 2:44 pm, during an interview with the Wellness Director, she confirmed that two planter pots located near the front entrance of the facility contained cigarette butts and there was no designated ash tray available. C. On 07/18/22 at 10:52 am, during an interview	A 067		

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A 067	Continued From page 76 with the Administrator at the exit conference she confirmed that two planter pots located near the front entrance of the facility contained cigarette butts and there was no designated ash tray available.	A 067		
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides	A 068	A 068 7NMAC 8.2.68 Hospice 1.All Facility Direct care staff will complete Hospice training as part of their on boarding through the Relias platform. Record of the trainings will be kept in direct care staffs personal file. Monthly in services will be provided to all direct staff through local Hospice providers. Documentation of these meetings will be kept in a binder in Director of Health and Wellness office. 2.ISPs for each resident will include a breakdown of all hospice services provided when applicable. A team meeting will be scheduled with resident, hospice and facility upon admission to hospice to ensure that all care needs are being met by both teams. A new ISP will be put in to place upon admission and will be updated as needs change. Team meetings will be scheduled as needs change. One hour of palliative/hospice training specific to the residents ISP will conducted annually. Records of this training will be kept in direct care staff's personal file.	4/1/2023

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A 068	Continued From page 77 physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that	A 068		

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	7117	A. BUILDING: _____ B. WING _____	C 07/18/2022

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A 068	Continued From page 78 identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team	A 068		

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A 068	Continued From page 79 meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and	A 068		

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A 068	Continued From page 80 also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified. E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010]	A 068		

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A 068	Continued From page 81 This REQUIREMENT is not met as evidenced by: 7.8.2.68 A (5) B (1) C, D (2) Based on record review and interview, the facility failed to ensure that: 1. There was documentation outlining the care and services to be provided 2. Direct Care Staff (DCS) had received the required six (6) hours of palliative/hospice training including one hour specific to resident's Individual Service Plan (ISP) annually when the facility is providing care and services for hospice residents. 3. Provide documentation for an updated Individual Service Plan (ISP) when a resident was placed on hospice outlining the services 4. Provide documentation that team meetings were held before residents are placed on hospice These deficient practices could likely result in the 2 (R #s 10 & 20) residents on Hospice whose files were reviewed for compliance, to be at risk of harm or injury if the DCS do not know the proper methods for providing care and services for Hospice residents. Findings related to DCS training: A. Record review of DCS #4's (hire date 03/07/21) training files, revealed no documentation that palliative/hospice training was completed. B. Record review of DCS #10's (hire date 06/22/20) training files, revealed no documentation that palliative/hospice training was completed. C. Record review of DCS #20's (hire date 04/03/06) training files, revealed no	A 068		

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A 068	Continued From page 82 documentation that palliative/hospice training was completed. D. Record review of DCS #21's (hire date 11/23/19) training files, revealed revealed no documentation that palliative/hospice training was completed. E. On 07/08/22 at 2:44 pm, during an interview, the Assistant Wellness Director confirmed that there was no documentation to show that palliative/hospice training was completed for the 4 DCS files reviewed. Findings regarding Hospice/Facility/Family Meeting: F. Record review of R #10's resident files revealed no documentation: 1. Outlining the care and services to be provided 2. That a team meeting was convened prior to admission into hospice. 3. A new ISP detailing to new care. G. On 06/29/22 at 2:05 pm, during an interview with DCS # 8, she confirmed that she had provided us with all document for R #10, and that the documents above were not on file. H. Record review of R #20's resident file, revealed no documentation: 1. Outlining the care and services to be provided 2. That a team meeting was convened prior to admission into hospice 3. A new ISP detailing to new care. I. On 07/18/22 at 10:52 am, during an interview with the Administrator at the exit conference she confirmed the findings above.	A 068		

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A 068	Continued From page 83 J. On 07/19/22 at 1:28 pm, during an interview with R #20's Power of Attorney (POA), he stated that R #20 had been admitted to Memory Care Unit (MCU) and recently placed on hospice.	A 068		