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 _____	R-C 09/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments The following deficiencies were cited during an onsite Revisit/Follow-up survey completed on [redacted]/23 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living for Adults. Resident Census: 140 ABBREVIATIONS: Resident: R Direct Care Staff: DCS Executive Director: ED Director of Health and Wellness: DHW Assistant Director of Health and Wellness: ADHW Memory Care Director: MCD Individual Service Plan: ISP Medication Administration Record: MAR Milligrams: mg Milliliter: ml Gram: gm Enteric-Coated: EC Delayed Release: DR Film-Coated: F/C Extended-Release: ER Procedural Reaction Time: PRT Hydrochloride: HCL Pound: lb Ounce: oz Memory Care Unit: MCU Assisted Living: AL	{A 000}		
{A 020}	7 NMAC 8.2.20 Admissions and Discharge 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	{A 020}	A 020 7 NMAC 8.2 20 Admissions and Discharge 1. Facility Administrator has added Senate Bill (SB) 0335 - 2013 as an addendum to all existing residnets agreements with signatures by resident or POA. All new admissions will sign Senate Bill (SB) 0335 - 2013 with agreement signing.	[redacted]023

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{A 020}	Continued From page 1 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; (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	{A 020}	2. Facility's Business office manger will audit all residents financial files to ensure that Senate Bill (SB) 0335 - 2013 has been signed by all residents. Resident files will be audited monthly for compliance. 3. Morada Albuquerque residency agreement has been updated on [redacted]2023 to include all components required by NMAC 7.8 20 including facilities bed hold policy on pg.14 item 11. 4. 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, as well as any resident who moved in with current ownership Morada Albuquerque prior to [redacted]/2023. The new residency agreement or addendum will include change of ownership and the bed hold policy. 5. A copy of the signed residency agreement will be kept in residents financial file.	

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{A 020}	Continued From page 2 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; (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	{A 020}		

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{A 020}	Continued From page 3 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 maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific	{A 020}		

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{A 020}	Continued From page 4 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: This is an uncorrected deficiency from survey dated [redacted]/22. 7.8.2.20 A (1, 5, 11) Refer to Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A	{A 020}		

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{A 020}	Continued From page 5 CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings. B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them. C. For the purposes of this section, "assisted living facility" means a facility required	{A 020}		

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{A 020}	Continued From page 6 to be licensed as an assisted living facility for adults by the department of health." SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately. Based on record review and interview the facility failed to ensure for [redacted] of [redacted] residents whose Admission Agreements were reviewed for compliance that: 1. New Admission/Discharge Agreements were created to include all parties (new Owner) of the agreement, when a change in ownership occurred on [redacted]'21. 2. They included a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013. 3. They 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, if the agreement does not include all parties (new Owner) to the agreement. 2. The residents not receiving a refund of monies owed from the facility or being aware of potential additional charges that can occur. 3. 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 (admission date: [redacted] resident file revealed no documentation of a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 -	{A 020}		

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{A 020}	Continued From page 7 2013. B. Record review of R #2's (admission date: [redacted] resident file revealed no documentation: 1. That the Admission Agreement included all parties (new Owner) involved in the agreement, when change of ownership occurred on [redacted]21. 2. Of a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013. C. Record review of R #3's (admission date: [redacted] resident file revealed no documentation of a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013. D. Record review of R #6's (admission date: [redacted] resident file revealed no documentation: 1. That a bed hold policy was included in the Admission Agreement dated [redacted]21. 2. Of a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013. E. Record review of R #8's (admission date: [redacted]20) resident file revealed no documentation: 1. The Admission Agreement dated [redacted]/20 included all parties (new Owner) involved in the agreement, when change of ownership occurred on [redacted]21. 2. Of a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013. F. Record review of R #9's (admission date: [redacted]13) resident file revealed no	{A 020}		

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{A 020}	Continued From page 8 documentation: 1. The Admission Agreement dated [redacted]23 included all parties (new Owner) involved in the agreement, when change of ownership occurred on [redacted]/21. 2. Of a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013. G. Record review of R #14's (admission date: [redacted] resident file revealed no documentation: 1. That the bed hold policy was included in the Admission Agreement dated [redacted]21. 2. Of a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013. H. On [redacted]23 at 2:00 pm, during an interview, the Executive Director confirmed: 1. The Admission Agreements for R #s 2, 8 and 9 included all parties (new Owner) involved in the Agreement, when the change of ownership occurred on [redacted]21. 2. There was no bed hold policy in the Admission Agreements for R #s 6 and 14. 3. The refund upon death policy was not in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013 for R #s 1, 2, 3, 6, 8, 9 and 14.	{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 authenticated by the signature of the person making the entry. Resident records shall be	{A 021}	A 021 7NMAC 8.2.21 Resident Records 1.Facility Health & Wellness Director or Assistant Health & Wellness Director 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.Assistant Health & Wellness Director will take updated photos of all current residents and place in personal file by [redacted]2023. 3. Health & Wellness Director will audit residents charts monthly to ensure compliance.	[redacted]023

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{A 021}	Continued From page 9 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; (o) legal documentation relevant to commitment or guardianship status;	{A 021}		

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{A 021}	Continued From page 10 (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 (12) upon the death or transfer of a resident, documentation of the disposition of the resident's	{A 021}		

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{A 021}	Continued From page 11 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: This is an uncorrected deficiency from a survey dated 07/18/22 7.8.2.21 A (5) (d) Based on record review and interview, the facility failed to ensure for [redacted] residents whose records were reviewed for compliance, that there was a recent photograph of the resident in their resident file. This deficient practice could likely result in the residents to be at risk of harm, if residents	{A 021}		

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{A 021}	Continued From page 12 receive the wrong care and services by the DCS because there was no identifying photograph in the resident's file. The findings are: A. Record review of R #1's resident file (date of admission [redacted]) revealed it did not include a recent photograph of the resident. B. Record review of R #3's resident file (date of admission [redacted] revealed it did not include a recent photograph of the resident. C. Record review of R #8's resident file (date of admission [redacted]) revealed it did not include a recent photograph of the resident. D. On [redacted]23 at 2:00 pm, during an interview, the ED confirmed that the files for R #s 1, 3, and 8 did not include a recent photograph of the resident.	{A 021}		
{A 026}	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender.	{A 026}	A026 7 NMAC 8.2.26 Individual Service Plan 1.Assessment and ISP will be completed within 10 days of 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 residents 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 be evaluated and signed off on by a licensed practical nurse, registered nurse, or a physician extender. 3. Facility Administrator will audit charts monthly to ensure that compliance is being met and in a timely manor.	[redacted]/2023

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{A 026}	Continued From page 13 (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 provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: This is an uncorrected deficiency from survey dated 07/18/22. 7.8.2.26 A (2) (3) Based on record review and interview, the facility failed to ensure for [redacted] of [redacted] residents whose Individual Service Plans (ISP's) were	{A 026}		

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{A 026}	Continued From page 14 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). These deficient practices could likely to result in the residents not receiving appropriate care/services by Direct Care Staff (DCS) if the ISPs are not completed on time, updated every six months or when there was a significant change in the resident's health and reviewed by an LPN, RN or PE. The findings are: A. Record review of R #1's (admission date: [redacted] resident file, revealed the following: 1. ISP dated [redacted]23, was not completed within 10-days after admission [redacted] 2. There was no documentation that the ISP dated [redacted]23 was reviewed by an LPN, RN or PE. B. Record review of R #3's (admission date: [redacted] resident file, revealed the following: 1. ISP dated [redacted]23, was not completed within 10-days after admission [redacted] 2. There was no documentation that the ISP dated [redacted]23 was reviewed by an LPN, RN or PE. C. Record review of R #4's (admission date: [redacted] resident file, revealed no documentation that the most recent ISP dated [redacted]23 was revised at a minimum of every six months as required by regulation.	{A 026}		

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{A 026}	Continued From page 15 D. Record review of R #7's (admission date: [redacted] resident file, revealed there was no documentation that the ISP dated [redacted]23 was reviewed by an LPN, RN or PE. E. Record review of R #10's (admission date: [redacted] resident file, revealed the following: 1. ISP dated [redacted]22 was not revised at a minimum of every six months as required by regulation. 2. There was no documentation that the ISP dated [redacted]23 was reviewed by an LPN, RN or PE. F. Record review of R #11's (admission date: [redacted] resident file, revealed there was no documentation that the ISP dated [redacted]23 was reviewed by an LPN, RN or PE. G. On [redacted]/23 at 1:20 pm, during an interview, the Business Office Manager confirmed that the ISP's for R#'s 1, 3, 7, 10 and 11 were not being signed or reviewed by an LPN, RN or PE because the facility did not have a nurse at the time they were completed. H. On [redacted]23 at 1:29 pm, during an interview, the Business Office Manager confirmed that R #4's ISP dated [redacted]23, had not been reviewed and/or if needed updated at a minimum of every 6 months by and RN, LPN, or PE.	{A 026}		
{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.	{A 032}	A 032 7 NMAC 8.2.32 Reporting of Incidents 1. Director of Health and Wellness or Memory Care Director 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.	[redacted]2023

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{A 032}	Continued From page 16 (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: This is an uncorrected deficiency from a survey dated [redacted]22. See survey [redacted]	{A 032}	2.Director of Health and Wellness or Memory Care Director 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 Administrator, Director of Health and Wellness, Assistant Health and Wellness Director and Memory Care Director will watch Incident Management Training Video provided by the NM Health Care Association and test congruent to training. To be completed by [redacted]2023.	
{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	{A 034}	A 034 7 NMAC 8.2.34 Custodial Drug Permits 1.Health & Wellness 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.	[redacted]2023

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{A 034}	Continued From page 17 this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (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	{A 034}	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.Health & Wellness Director 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 staffs personal file. This will be completed on [redacted]2023. 4. Director of Health & Wellness will do a weekly walk through of O2 storage room to ensure compliance is met.	

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{A 034}	Continued From page 18 for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such 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	{A 034}		

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{A 034}	Continued From page 19 administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: This is an uncorrected deficiency from survey dated [redacted]/22. 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	{A 034}		

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{A 034}	Continued From page 20 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 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	{A 034}		

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{A 034}	Continued From page 21 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. 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 observation and interview, the facility failed to ensure that oxygen cylinder tanks were stored securely and protected from accidental damage or dislocation. This deficient practice could likely result in the [redacted] residents listed on the resident census, provided by the Director of Health and Wellness on [redacted]23, to be at risk of harm, injury, or death if oxygen cylinder tanks were to fall over damaging the valve, causing them to	{A 034}		

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{A 034}	Continued From page 22 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: The findings are: A. On [redacted]23 at 12:54 pm, during observation of the Memory Care Unit (MCU) oxygen storage room (2nd floor exterior storage) three (3) large cylinder tanks were observed to be unsecured. B. On [redacted]/23 at 12:59 pm, during observation in the Assisted Living (AL) oxygen storage room (3rd floor) the following oxygen cylinder tanks were observed to be unsecured: 1. Fifteen (15) unsecured small oxygen cylinder tanks. 2. Three (3) unsecured large oxygen cylinder tanks. C. On [redacted]/23 at 2:00 pm, during an interview, the Executive Director confirmed all the oxygen cylinder tank findings listed above. D. On [redacted]3 at 12:52 pm, during observation of R #18's resident room, one (1) small oxygen cylinder tank was observed to be unsecured. E. On [redacted]23 at 1:54 pm, during an interview, the Executive Director confirmed the unsecured small oxygen cylinder tank in R #18's[redacted]	{A 034}		[redacted]2023
{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	{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. Direct care staff will provide initials and signature when assisting with or administering medication.	

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{A 035}	Continued From page 23 federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s 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),	{A 035}	3. Health & Wellness Director and the Assistant Health And Wellness Director will do Monthly MAR audits to ensure compliance is met.	

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{A 035}	Continued From page 24 intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of 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);	{A 035}		

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{A 035}	Continued From page 25 (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (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	{A 035}		

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{A 035}	Continued From page 26 (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: This is an uncorrected deficiency from a survey dated [redacted]22 7.8.2.35 G (4, 5, 16) Based on record review and interview, the facility failed to ensure for [redacted] residents whose MARs were reviewed for compliance were accurate, complete, and included all required information: 1. The diagnosis or reason for the medication. 2. The name of the medication, including the drug product brand name and the generic name. 3. The initials and signature of the person assisting with or administering the medication. These deficient practices could likely result in the residents to be at risk of harm, illness, or medication errors occur, if the Direct Care Staff	{A 035}		

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{A 035}	Continued From page 27 who assist residents with the self-administration of medications (DCSAM) do not: 1. Understand what the medication is being given for, because diagnosis/reason for the medication was not listed. 2. Recognize the name of the medication, if both brand name and generic name are not listed. 3. Do not initial when medications are given/taken. The findings are: R #1: A. Record review of R #1's MAR dated [redacted]/23 [redacted]23 revealed that the following listed medications did not included both the brand and generic names for the medications: [redacted]	{A 035}		

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{A 035}	Continued From page 28 [redacted] B. On [redacted]23 at 1:12 pm, during an interview, the MCD confirmed the following medications for R #1 were missing both the brand and generic names on R #1's MAR dated [redacted] [redacted] [redacted] R #2: C. Record review of R #2's MAR dated	{A 035}		

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{A 035}	Continued From page 29 [redacted]/23-[redacted]23 revealed that the following listed medications did not include both the brand and generic name for the medications: [redacted] D. On [redacted]23 at 1:12 pm, during an interview, the MCD confirmed the following medications for R #2 did not include both the brand/generic names on R #2's MAR dated [redacted]/23-[redacted]23 [redacted] E. Record review of R #13's MAR dated [redacted]23 through [redacted]/23 revealed the following: 1. MAR's dated [redacted]/23 through [redacted]23 did not have a diagnosis/reason for the following medications: [redacted] 2. MAR's dated [redacted]23 through [redacted]23: a. Did not have a both the brand/generic name for the following medications:	{A 035}		

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{A 035}	Continued From page 30 [redacted] b. Did not have a diagnosis/reason for the following medications: [redacted] 3. MAR's dated [redacted]23 through [redacted]/23 did not have a diagnosis/reason for the following medications: [redacted] F. On [redacted]23 at 2:00 pm, during an interview, the Executive Director confirmed the above findings related to R #13's MARs.	{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 premises and that govern the following requirements.	{A 036}	A 036 7 NMAC 8.2.36 Nutrition 1.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. 2.Facility Director of Dietary will 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.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 all kitchen equipment, the kitchen walls and floors weekly as well as when needed.	[redacted]/2023

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{A 036}	Continued From page 31 (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; (b) preparation and serving food; (c) safety in food handling;	{A 036}	5. Facility Administrator will complete weekly kitchen audits to ensure compliance.	

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{A 036}	Continued From page 32 (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 be cleaned in accordance with procedures that include separate steps for prewashing, washing,	{A 036}		

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{A 036}	Continued From page 33 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 five (5) calendar day supply of non-perishables or canned foods is available for the residents.	{A 036}		

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{A 036}	Continued From page 34 (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 back-flow or contamination by condensation, leakage, rodents or vermin.	{A 036}		

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{A 036}	Continued From page 35 (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: This is an uncorrected deficiency from a survey dated [redacted]/22 7.8.2.36 B 4, C 1 (a, c), 4, D 3	{A 036}		

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{A 036}	Continued From page 36 Based on observation and interview, the facility failed to ensure that: 1. A daily log of the recorded temperatures for all facility refrigerators, freezers, and steam tables were 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. Refrigerators and freezers shall be kept clean and sanitary at all times. 5. 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 [redacted] residents listed on the census provided by the Director of Health Wellness on [redacted], to be at risk of harm from contracting foodborne illnesses caused by bacteria if: 1. There is no documentation of a daily log of recorded temperatures for the facility refrigerators and freezers for the last 30-days. 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 them do not have lids. 4. There is no documentation that food storage, refrigeration, and food cooking/preparation areas are maintained in a clean, temperature controlled, safe and sanitary condition.	{A 036}		

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{A 036}	Continued From page 37 5. Food, was not stored properly (dated, labeled), and leftovers were kept longer than (3) three days after being served the first time. The findings are: Findings related to the MCU Activities/Television area: A. On [redacted]23 at 12:24 pm, during an observation of the MCU Activities/Television area, the following was observed: 1. One gallon of expired (expiration date 08/19/23)orange juice in the refrigerator. 2. One 6-oz container of expired (dated 08/30/23) yogurt in the refrigerator. 3. One pint of gelato in the freezer, undated. 4. One 4-oz styrofoam bowl of an unidentified, frozen green food, undated. 5. The freezer was observed to be dirty with an unidentified, red, sticky liquid frozen to the bottom. B. On [redacted]23 at 12:50 pm, during an interview, the MCD confirmed the following in the MCU Activities/Television area refrigerator: 1. There was one gallon of expired orange juice 2. There was one 6-oz container of expired yogurt 3. There was one pint of gelato. 4. There was one, 4-oz styrofoam bowl of an unidentified, frozen green food, undated. 5. The freezer was observed to be dirty with an unidentified, red, sticky liquid frozen to the bottom. Findings related to the MCU Dinette: C. On [redacted]23 at 12:29 pm, during an observation of the MCU Dinette, the following was	{A 036}		

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{A 036}	Continued From page 38 observed: 1. A beverage cart that was dirty (with crumbs and stains [dried liquids/foods]). 2. A cabinet under the sink that was dirty (with crumbs, stains, and trash. 3. A cabinet under the stove that was dirty (with crumbs, stains, trash, and clutter). 4. A dirty sink (with stains, unknown food or liquid stuck to the bottom, and dirty dishes in it). 5. A dirty stovetop (with stains and crumbs). D. On [redacted]23 at 12:50 pm, during an interview, the MCD confirmed the following for the MCU Dinette: 1. There was a dirty (with crumbs and stains) beverage cart. 2. There was a dirty (with crumbs, stains, and trash) cabinet under the sink. 3. There was a dirty (with crumbs, stains, trash, and clutter) cabinet under the stove. 4. There was a dirty (with stains, unknown food or liquid stuck to the bottom, dirty dishes) sink. 5. There was a dirty (with stains and crumbs) stovetop. Findings related to the AL Kitchen: E. On [redacted]23 at 10:07 am, during an observation of the AL Kitchen, the following was observed, the: 1. Temperature logs for the big freezer, salad bar, and refrigerators had not been recorded since 08/10/23. 2. Floor in the kitchen was dirty (dark stains) in multiple places. 3. Walls in the kitchen were dirty (stains, spills, smudges of food and other debris) in multiple places. 4. Steam table was dirty (full of crumbs and food debris).	{A 036}		

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{A 036}	Continued From page 39 5. Exterior of the oven was dirty (stains, crumbs, caked on grease). 6. Pans (not being used at that time) on the baking pan cart had crumbs and grease. 7. Janitor closet (a mop bucket and other cleaning supplies) had dirty floors (dirt, trash, debris and stains). F. On [redacted]3 at 10:15 am, during an interview with, DCS #s 11 and 14, they confirmed the: 1. Temperature logs for the big freezer, salad bar, and refrigerators had not been done since 08/10/23. 2. Floor in the kitchen was dirty (dark stains) in multiple places. 3. Walls in the kitchen were dirty (stains, spills, smudges of food and other debris) in multiple places. 4. Steam table was dirty and full of crumbs and debris. 5. Exterior of the oven was dirty (stains, crumbs, caked on grease). 6. Pans (not being used at that time) on the baking pan cart had crumbs and grease. 7. Janitor closet (a closet with a mop bucket and other cleaning supplies) had dirty floors (dirt, trash, debris and stains). Findings related to the MCU Kitchenette: G. On [redacted]23 at 10:29 am, during an observation of the MCU Kitchenette, the following was observed: 1. Dirty walls near the outlet by the serving bar. 2. A wet coffee filter with coffee grounds sitting on the serving bar. 3. Dirty walls near behind the sink. 4. Multiple spots and stains on the floor. 5. Multiple spots, stains, and crumbs on the toaster.	{A 036}		

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{A 036}	Continued From page 40 6. Multiple crumbs and stains inside the upper cabinets by the refrigerator. 7. Multiple crumbs and stains on the lower shelf holding appliances near the serving bar. 8. Multiple spots and stains on the exterior of all the upper cabinet doors. 9. A broken outlet near the serving bar. H. On [redacted]23 at 10:29 am, during an observation of the MCU Kitchenette, the following was observed in the freezer: 1. It was dirty with trash (an empty plastic bag and crumbs). 2. A brown liquid substance was spilled and frozen all over the bottom of the freezer. 3. An 8 oz paper coffee cup with no date or label. 4. An open, 1 lb 8 oz container of eclairs with no date or label. I. On [redacted]/23 at 10:51 am, during an interview with the MCD, she confirmed the following findings were observed for the MCU Kitchenette: 1. Dirty walls near the outlet by the serving bar. 2. A wet coffee filter with coffee grounds sitting on the serving bar. 3. Dirty walls near behind the sink. 4. Multiple spots and stains on the floor. 5. Multiple spots, stains, and crumbs on the toaster. 6. Multiple crumbs and stains inside the upper cabinets by the refrigerator. 7. Multiple crumbs and stains on the lower shelf holding appliances near the serving bar. 8. Multiple spots and stains on the exterior of all the upper cabinet doors. 9. A broken outlet near the serving bar. J. On [redacted]23 at 10:51 am, during an interview, the MCD confirmed the following findings for the freezer in the MCU Kitchenette:	{A 036}		

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{A 036}	Continued From page 41 1. It was dirty with trash (an empty plastic bag and crumbs). 2. A brown liquid substance was spilled and frozen all over the bottom of the freezer. 3. An 8 oz paper coffee cup with no date or label. 4. An open, 1 lb 8 oz container of eclairs with no date or label. Findings related to the MCU Dining Room: K. On [redacted]23 at 10:38 am, during an observation of the MCU dining room, the following was observed: 1. A trash can near the serving bar with food and other trash and no lid. 2. Dirty walls and baseboards near the air conditioner by the window. L. On [redacted]/23 at 10:51 am, during an interview, the MCD confirmed the following findings for the MCU dining room: 1. A trash can near the serving bar with food and other trash and no lid. 2. Dirty walls and baseboards near the air conditioner by the window. Findings related to the facility's 3rd floor ice cream parlor/common area: M. On [redacted]23 at 1:08 pm, during an observation of the facility's 3rd floor ice cream parlor/common area, one empty reach in freezer was observed to be dirty and had spilled ice cream in the interior of the freezer. N. On [redacted]23 at 2:00 pm, during an interview with the ED, she confirmed the findings related to the dirty reach in freezer located in the 3rd floor ice cream parlor/common area.	{A 036}		

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{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: This is an uncorrected deficiency from survey dated 07/18/22. 7.8.2.38 A C Based on observation and interview, the facility failed to ensure that: 1. The interior and exterior of the facility was maintained in a safe, clean, sanitary/attractive	{A 038}	A 038 7 NMAC 8.2.38 Housekeeping Services 1.Facilty Operations Director will ensure that housekeepers are keeping all common areas free of debris. Weekly walk through of all outdoor spaces will also be conducted to ensure compliance. 2. 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. 3.Facility's Dietary Director will do weekly walk through's of both the Main Kitchen and Memory care Kitchen to ensure all cleaning logs are being kept up to date and that proper sanitation is being practiced and compliance is being met.	[redacted]2023

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{A 038}	Continued From page 43 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. [redacted]actices could likely result in the [redacted] residents listed on the resident census list provided by the Director of Health and Wellness [redacted]23, to be at risk of harm, injury, or death if residents get ill from diseases caused by unsanitary conditions, or ingest or spill poisonous cleaning chemicals on themselves. The findings related to the Assisted Living (AL)area: A. On [redacted]23 at 9:40 am, during observation of an unlocked food pantry/storage room across from the facility's dining room, the following was observed: 1. Five (5) unsecured 32 fluid ounce (fl oz) spray bottles of fast foam degreaser. 2. Dirty (stained) walls. 3. Dirty (stained) shelves where canned food is being stored. 4. Dirty (stained) floors B. On [redacted]/23 at 10:04 am, during observation of the [Name of facility's Café], one (1) eaten apple core was observed to be discarded in a drawer. C. On [redacted]/23 at 10:10 am, during observation of a facility exit/entrance near resident room # 261 the following was observed: 1. Outdoor debris (leaves, dirty and bird feathers) were on the carpet. 2. Water damage to one (1) ceiling tile above the exit/entrance door.	{A 038}		

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{A 038}	Continued From page 44 D. On [redacted]3 at 10:16 am, during observation of one of the facility's common sitting areas near resident room [redacted] outdoor debris (leaves, dirty and bird feathers) were on the interior floor. E. On [redacted]23 at 10:19 am, during observation of the facility's outdoor gazebo patio, the following was observed: 1. Bird droppings (feces) throughout the courtyard grounds, walk paths, planters, seating area (chairs). 2. Three (3) dead birds on the courtyard grounds and walk paths. F. On [redacted]23 at 10:31 am, during observation of the facility's dining room, multiple stains were observed on the carpet. G. On [redacted]23 at 10:46 am, during observation of the facility's open laundry room near resident room [redacted] One (1) 16 fl oz bottle of antibacterial cleaner was on the table unsecured. H. On [redacted]23 at 11:00 am, during observation of the facility's open laundry room near resident room [redacted], the trash can was overflowing and trash (boxes and bags of trash) were sitting on the laundry room floor near the trash can. I. On [redacted]23 at 11:03 am, during observation of the facility's 3rd floor activity room, One (1) 16 oz spray bottle of disinfectant cleaner was unsecured and stored in an unlocked cabinet. J. On [redacted]23 at 11:20 am, during an interview, the Director of Health and Wellness confirmed the above findings. Findings related the Memory Care Unit (MCU):	{A 038}		

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{A 038}	Continued From page 45 K. On [redacted]/23 at 12:27 pm, during an observation of the MCU common sitting area, one (1) 10 oz spray bottle of room refresher, was unsecured in an unlocked cabinet. L. On [redacted]23 at 12:29 pm, during an observation of the MCU outdoor patio, one (1) bag of trash was sitting near the patio entrance/exit door. M. On [redacted]23 at 12:32 pm, during an observation of the MCU's activity room, the following were unsecured in an unlocked cabinet: 1. Five (5) 4 fl oz bottles of acrylic paint 2. Two (2) unknown size bottles of washable paint 3. One (1) 8.45 fl oz tub of acrylic paint 4. Two (2) 16.9 bottles of acrylic paint 5. Seven (7) 8 oz bottles of paint N. On [redacted]23 at 12:54 pm, during an interview, the MCU Director confirmed the above findings related to the MCU. O. On [redacted]/23 at 10:22 am, during an observation of the facility's outdoor walk path, connecting the two buildings, a strong sewer like odor was present in the area. P. On [redacted]23 at 10:24 am, during in interview, the Executive Director confirmed the sewer like odor that was present. Q. On [redacted]23 at 10:48 am, during an observation of the MCU, there was a sewer like odor present in the hallway near the dining room. R. On [redacted]/23 at 10:56 am, during an interview, the MCU director confirmed the sewer like odor	{A 038}		

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{A 038}	Continued From page 46 that was present. S. On [redacted]23 at 1:10 pm, during an observation of the facility's open laundry room near resident room [redacted] the trash can was overflowing, and trash was sitting on the laundry room floor next to the trash can. T. On [redacted]23 at 2:00 pm, during an interview, the Executive Director confirmed the findings related to the trash in the laundry room near resident room[redacted]	{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 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	{A 047}	A 047 7 NMAC 8.2.47 Lighting and Lighting Fixtures 1. Facility Operations Director will replace all emergency lighting lights with new bulbs by [redacted]2023. 2. Facility Operations Director will perform a manual test of all emergency lighting once a month to ensure that they are operating properly. Record of these test will be kept in logging system TELS. 3. Facility Administrator will review logs monthly to ensure compliance.	[redacted]2023

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{A 047}	Continued From page 47 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 E Based on observation and interview the facility failed to ensure that all the emergency lights in the facility were in working order. This deficient practice could likely result in the [redacted] residents identified on the resident census for the AL side, provided by the Director of Health and Wellness on [redacted]/23, to be at risk of harm, injury, or death, if there is a power outage or other emergency requiring evacuation and the residents cannot see to safely exit the building. The findings are: A. On [redacted]/23 at 9:57 am, during an observation of the facility, the following emergency lights were not working when tested: 1. The emergency light to the right of the [Name of Cafe] in the hallway. 2. The emergency light across from the Receiving Employees Only sign at the end of the hallway on the 2nd floor. 3. The emergency light near elevator C on the 2nd floor. 4. The emergency light near room [redacted] 5. The emergency light near room [redacted] 6. The emergency light across from room [redacted] 7. The emergency light near room [redacted] 8. The emergency light near room [redacted] 9. The emergency light near room [redacted] 10. The emergency light near room [redacted] 11. The emergency light near room [redacted]	{A 047}		

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{A 047}	Continued From page 48 12. The emergency light across from the Card Room. 13. The emergency light near room [redacted] 14. The emergency light near room [redacted] 15. The emergency light near room [redacted] 16. The emergency light near room [redacted] 17. The emergency light near room [redacted] 18. The emergency light near room [redacted] 19. The emergency light across from the Arts and Crafts room. B. On [redacted]/23 at 10:26 am, during an observation of the facility, the emergency light in the hall near the Community Sales Director's office was broken (hanging and improperly secured) and not working when tested. C. On [redacted]/23 at 11:20 am, during an interview, the DHW and ADHW confirmed the following emergency lights were not working when tested: 1. The emergency light to the right of the [Name of Cafe] in the hallway. 2. The emergency light across from the Receiving Employees Only sign at the end of the hallway on the 2nd floor. 3. The emergency light near elevator C on the 2nd floor. 4. The emergency light near room [redacted] 5. The emergency light near room [redacted] 6. The emergency light across from room [redacted] 7. The emergency light near room [redacted] 8. The emergency light near room [redacted] 9. The emergency light near room [redacted] 10. The emergency light near room [redacted] 11. The emergency light near room [redacted] 12. The emergency light across from the Card Room. 13. The emergency light near room [redacted] 14. The emergency light near room [redacted] 15. The emergency light near room [redacted]	{A 047}		

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{A 047}	Continued From page 49 16. The emergency light near room [redacted] 17. The emergency light near room [redacted] 18. The emergency light near room [redacted] 19. The emergency light across from the Arts and Crafts room. 20. The emergency light in the hall near the Community Sales Director's office was broken (hanging and improperly secured) and not working when tested.	{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] This REQUIREMENT is not met as evidenced by: This is an uncorrected deficiency from survey	{A 059}	A 059 7 NMAC 8.2.59 Windows 1.Facilty Operations Director will repair and replace all window screens that are damaged. Operations 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 Operations Director 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. 3. Facility Administrator will do a weekly walk through of community grounds to ensure compliance.	[redacted]2023

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{A 059}	Continued From page 50 dated [redacted]/22. 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 [redacted] residents identified on the resident census provided by the Director of Health and Wellness on [redacted]23, 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 [redacted]23 at 12:46 pm, during observation of the Memory Care Unit's (MCU) dining room, one window had a torn screen. B. On [redacted]23 at 12:50 pm, during observation of MCU resident [redacted] had a window screen that was broken (bent frame). C. On [redacted]23 at 12:52 pm, during observation of MCU common living area, one window had a window screen that was broken (bent frame). D. On [redacted]23 at 12:54 pm, during an interview, the MCU Director confirmed the findings related to the damaged window screens in the MCU dining room, common living area and [redacted] E. On [redacted]23 at 10:17 am, during an observation of the facility's exterior grounds, one window screen was on the ground and appeared to have fallen off of the window of resident room	{A 059}		

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	7117	A. BUILDING: _____ B. WING _____	R-C 09/19/2023

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{A 059}	Continued From page 51 [redacted] F. On [redacted]/23 at 1:55 pm, during an interview,the Executive Director confirmed that the window screen belonging to [redacted] had fallen off.	{A 059}		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 B Reference NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition:	A 063	A 063 7 NMAC 8.2.63 Fire Extinguishers 1. Facility Operations Director will perform a monthly inspection on all fire extinguishers. Facility Operations Director will sign off on all extinguishers at the time of inspection. 2. 2. Facility Administrator will do a monthly walk through to ensure that all fire extinguishers have been inspected properly for compliance.	[redacted]/2023

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A 063	Continued From page 52 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. Based on observation and interview, the facility failed to ensure that the fire extinguishers were being inspected monthly as recommended by the manufacturer. This deficient practice could likely result in all [redacted] residents identified on the census by the Director of Health and Wellness (DHW) on [redacted]23, staff members, and other building occupants to be at risk of harm, injury, or death if a fire were to occur and the fire extinguishers do not work. The findings are: A. On [redacted]3 at 10:12 am, during an observation of the facility, the following fire extinguishers were found to not have been inspected monthly as recommended by the manufacturer: 1. The fire extinguisher near room [redacted] 2. The fire extinguisher near room [redacted] 3. The fire extinguisher near room [redacted] 4. The fire extinguisher near the Wellness Director's office. 5. The fire extinguisher near the 2nd floor elevator C. 6. The fire extinguisher near room [redacted] 7. The fire extinguisher near room [redacted] 8. The fire extinguisher near room [redacted] 9. The fire extinguisher near room [redacted] 10. The fire extinguisher near room [redacted] 11. The fire extinguisher near room [redacted] 12. The fire extinguisher near room [redacted]	A 063		

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A 063	Continued From page 53 13. The fire extinguisher near room [redacted] 14. The fire extinguisher near room [redacted] 15. The fire extinguisher near room [redacted] 16. The fire extinguisher near room [redacted] 17. The fire extinguisher near the Dining Room. 18. The fire extinguisher near the Executive Director's office. 19. The fire extinguisher near the Utility Room. 20. The fire extinguisher in the Staff Laundry Room. B. On [redacted]23 at 11:20 am, during an interview, the DHW and Assistant DHW confirmed the fire extinguishers near room [redacted] near the Wellness Directors office, ED office, Utility Room, Staff Laundry Room, Dining Room, and 2nd floor elevator C had not been inspected monthly as recommended by the manufacturer.	A 063		
{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 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]	{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. 2. Facility Operations Director will do a weekly walk through of exterior and clean up any cigarette butts that have been disposed of inappropriate container.	[redacted]2023

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{A 067}	Continued From page 54 This REQUIREMENT is not met as evidenced by: 7.8.2.67 B Based on observation and interview, the facility failed to ensure that staff were using a suitable noncombustible ash trays to dispose cigarette butts safely. This deficient practice could likely result in the [redacted]residents identified on the census provided by Director of Health and Wellness [redacted]23, to be at risk of harm or death if a fire were to occur because staff are not using suitable noncombustible ash trays to dispose cigarette butts safely. The findings are: A. On [redacted]/23 at 1:36 pm, during observation of the East side walk path; nine (9) cigarette butts (the remaining portion of a smoked cigarette) were discarded on the ground alongside of the walk path and not in a suitable ash tray. B. On [redacted]23 at 1:38 pm, during observation of the North East side walk path; three (3) cigarette butts were discarded on the ground alongside the walk path and not in a suitable ash tray. C. On [redacted]23 at 1:54 pm, during an interview, the Executive Director confirmed the above findings.	{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	{A 068}	A 068 7NMAC 8.2.68 Hospice 1.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.	[redacted]023

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{A 068}	Continued From page 55 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 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	{A 068}	2. Health and Wellness director will review and update all current residence receiving hospice services ISP's. Documentation of all care conferences including those with hospice will be kept in residence personal file. 3. Facility Administrator will do a monthly audit of residents receiving hospice services personal file to ensure compliance.	

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{A 068}	Continued From page 56 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 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	{A 068}		

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{A 068}	Continued From page 57 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 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	{A 068}		

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{A 068}	Continued From page 58 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 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.	{A 068}		

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{A 068}	Continued From page 59 (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] This REQUIREMENT is not met as evidenced by: This is an uncorrected deficiency from survey dated [redacted]22. 7.8.2.68 C Based on record review and interview, the facility failed to ensure for [redacted] residents whose Individual Service Plans (ISP's) were reviewed for compliance, that they were updated when the resident was placed on	{A 068}		

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{A 068}	Continued From page 60 hospice and outlined the services to be provided by the hospice agency. These deficient practices could likely result in the residents on Hospice to be at risk of harm or injury if DCS are not aware of how to properly care for the residents and are not aware of who is providing care and services. The findings are: A. Record review of R #7's (admission date: [redacted] Individual Service Plans (ISP) revealed that there was not an updated ISP to reflect when R #7 was admitted to Hospice on [redacted] B. Record review of R #9's (admission date: [redacted] ISP's dated [redacted]/22 and [redacted]23 revealed they were not updated when R #9 was admitted to Hospice on [redacted] and did not outline the services to be provided by the Hospice Agency. C. On [redacted]23 at 1:49 pm, during an interview, the Executive Director confirmed the above findings related to R #7's ISP not being updated and R #9's ISP not outlining the services to be provided by the Hospice Agency.	{A 068}		