STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7117	A. BUILDING: _____ B. WING _____	C 06/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Regulation Review Survey/Complaint survey completed on 06/05/24 for the state requirements of NMAC 7.8.2, Regulations for Assisted Livings for Adults. Complaint Intake NM [redacted] was investigated, and no deficiencies were cited. Complaint Intake NM [redacted] was investigated, and deficiencies were cited. Complaint Intake NM [redacted] was investigated, and no deficiencies were cited. Complaint Intake NM [redacted] was investigated, and no deficiencies were cited. Complaint Intake NM [redacted] was investigated, and no deficiencies were cited. Complaint Intake NM [redacted] was investigated, and no deficiencies were cited. Complaint Intake NM [redacted] was investigated, and no deficiencies were cited. Resident Census: 141	A 000		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid;	A 017	A 017 7NMA 8.2.17 Staff Training 1 Facilities Health & Wellness Director will ensure that all direct care staff complete required training prior to working the floor. 2.All direct care staff will be required to complete all required trainings utliizing the training platform provided. 3.Documetnation of these completed trainings will be kept in direct care staffs personal file located int he business office. 4.Direct care Satff will be responsible for completing monthly refresher courses on the training platform. 5.Facility Business Office Manager will do a monthly audit on all direct care staff files to ensure that compliance is being met and that records are up to date.	8/12/2024

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A 017	Continued From page 1 (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 C (1-12) Based on record review and interview, the facility failed to ensure that 1 Direct Care Staff (DCS #2) received 12 hours of orientation training in the topics required by regulation. This deficient practice could likely result in the	A 017		

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A 017	Continued From page 2 141 (R #s 1-141) residents listed on the resident census, provided by the Administrator on 05/20/24, being at risk of harm if receiving care and services by DCS who have not received the required trainings. The findings are: A. Record review of DCS # 2's (hire date 02/15/24) training files revealed the record did not contain any documentation of DCS #2 completed the 12 hours of orientation training in the following required areas: (1) Fire safety and evacuation training; (2) First aid; (3) Safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene, and (e) infectious and communicable (Illnesses caused by viruses or bacteria) disease control; (4) Confidentiality of records and resident information; (5) Infection Control; (6) Resident Rights; (7) Reporting requirements for abuse, neglect, or exploitation in accordance with 7.1.13 NMAC; (8) Smoking policy for staff, residents, and visitors; (9) Methods to provide quality resident care; (10) Emergency procedures; (11) Medication assistance, including the certificate of training for staff that assist with	A 017		

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A 017	Continued From page 3 medication delivery; (12) The proper way to implement a resident Individual Service Plan (ISP) (a comprehensive plan, developed by the interdisciplinary team that identifies all treatment, habilitation and services for a resident) for staff that assist with ISPs. B. On 05/21/24 at 1:10 pm, during an interview with the Administrator, she confirmed that DCS #2 had not completed any of the required 12-hours of orientation training.	A 017		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc;	A 025	A 025 7 NMAC 8.2.25 Resident Evaluation 1. Facility Health & Wellness Director will ensure that all assessments and ISP's are completed in a timely manor and signed off by an LPN within 14 days of assessment/ISP being completed. 2. Facility Health & Wellness Director will make appropriate adjustments and changes to residents assessment/ISP as needed for change of condition. 3. Facility Administrator will work with Health and Wellness director to do a monthly audit on all assessments/ISP's to ensure that all have been updated appropriately and that they have been signed off by a LPN.	8/12/2024

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A 025	Continued From page 4 (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 C (17) E	A 025		

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A 025	Continued From page 5 Based on record review and interview, the facility failed to ensure for 1 (R #9) of 3 (R #s 2, 7, 9) residents whose evaluations were reviewed for compliance that the evaluations. 1. Documented the following behaviors or status: a. Safety need/high-risk behaviors; history of wandering (traveling aimlessly from place to place). 2. Were reviewed and, if needed, revised by a licensed practical nurse (LPN), registered nurse (RN) or physician extender (PE) at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. These deficient practices could likely result in the resident to be at risk of not getting the care and services needed if the Direct Care Staff (DCS) does not know the residents' correct needs. The findings are: A. Record review of a Facility Self Report (NM [redacted] revealed the Memory Care Director reported on 05/19/24 that: 1. R #9 was wandering the facility and was unable to be located when R #9's son and daughter-in-law came to visit [redacted] 2. The facility actively put in place an elopement process(drill to find missing resident) to locate missing residents 3. R #9's son searched the surrounding neighborhood and located R #9 near [name of intersection] approximately one mile away from the facility, and transported [redacted] R #9) back to the facility. 4. During each shift, R #9 was monitored with frequent checks and required more attention, as documented.	A 025		

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A 025	Continued From page 6 5. Staff will encourage R #9 to join group activities and find an activity that interest [redacted] which is a documented intervention to reduce wandering. B. On 05/22/24 at 1:58 pm, during an interview, DCS #11 confirmed: 1. R #9 was new to the facility (admission date: [redacted], and he (DCS #11) started witnessing R #9 wandering the facility [redacted] R #9) would vocalized [redacted] wanted to leave and find [redacted] family; R #9 is still acclimating (process in which an individual organism [a single living thing that carries out life activities through organs with separate functions but interdependent on each other] adjusts to a change in its environment) to the facility. 2. On [unknown date/separate incident from the incident that occurred on 05/19/24]: a. R #9 walked out the facility's front door, and the front desk staff called DCS to report that R #9 had walked out the facility's front door. b. R #9 was found approximately 0.2 miles from the facility, near the bridge on [street name]. c. DCS [unknown names] had to convince R #9 to come back to the facility, and R #9 stated [redacted] was trying to return [redacted] daughter's house. C. On 05/23/24 at 8:40 am, during an interview, Executive Director (ED) confirmed on 05/19/24: 1. R #9 was wandering the facility, and when R #9's family came to visit, they could not locate [redacted] 2. The facility immediately activated their elopement protocol. 3. R #9's family was able to locate R #9 by [name of intersection] approximately one mile away from the facility and brought [redacted] R #9) back to the facility. 4. The facility staff put R #9 on routine checks	A 025		

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A 025	Continued From page 7 (scheduled checks) and was being monitored closely. 5. The ED met with R #9's family to update [redacted] care plan (date unknown) and will work with R #9's family and R #9 to determine [redacted] needs a higher level of care. D. On 05/24/24 at 9:40 am, during an interview, the Memory Care Director (MCD) confirmed: 1. There have been a couple of times that they (staff) have seen R #9 walk outside of the facility and have to redirect [redacted] R #9) back inside. 2. DCS #6 confirmed with her (MCD) that R #9 wanders through the hallway and that [redacted] pack[redacted] stuff and says [redacted] eady to leave. E. On 05/28/24 at 10:40 am, during an interview, R #9 confirmed: 1. On 05/19/24 [redacted] eft the facility walking but could not remember where [redacted] vent or why [redacted] left [redacted] confirmed that [redacted] daughter-in-law brought [redacted] back to the facility. 2[redacted] ould not remember if [redacted] ad a fall while away from the facility on 05/19/24. 3. "About a month ago," [redacted] left the facility and walked to the golf course, where staff (unknown who) brought [redacted] back to the facility. F. Record review of R #9's resident evaluation dated 04/18/24 revealed: 1. Under the section titled Wandering Behavior, stated, "The resident does not wander at time of assessment." 2. The resident evaluation does not reflect R #9's safety needs/high-risk behaviors, or history of wandering, as stated during an interview with: a. DCS #11 on 05/22/24. b. MCD on 05/24/24.	A 025		

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A 025	Continued From page 8 G. Record review of R #9's resident evaluation dated 05/23/24 (four days after the elopement incident), signed and dated by the Assistant Director of Health and Wellness, revealed: 1. The resident evaluation does not reflect R #9's safety needs/high-risk behaviors (wandering) and stated, "The resident does not wander at time of assessment." 2. The resident evaluation does not reflect the need for frequent safety checks as reported in the Facility Self Report (NM 74740), dated 05/21/24, and during an interview with the ED on 05/23/24. 3. The resident evaluation does not reflect the need for assistance with encouraging and finding an activity for R #9, as reported in the Facility Self Report (NM #74740), It states, "Resident is independent in life enrichment (daily activities) and socialization activities." 4. The resident evaluation did not contain any documentation that the evaluation was reviewed and if needed revised by a LPN, RN or PE. H. On 05/24/24 at 10:19 am, during an interview, the Assistant Director of Health and Wellness confirmed: 1. The resident evaluation dated 05/23/24: a. Was completed after the incident on 05/19/24 and did not reflect R #9's wandering behaviors and the change [redacted] level of care. b. Was not reviewed or revised by an LPN, RN or PE. 2. The resident evaluations dated 04/18/24: a. Did not reflect R #9's wandering behaviors or history of wandering as stated in an interview with DCS #11 on 05/22/24 and with the ED on 05/24/24. b. Were not reviewed or revised by a LPN, RN, or PE.	A 025		

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A 025	Continued From page 9 I. Record review of R #9's (updated) resident evaluation dated 05/24/24 revealed no documentation showing that an LPN, RN, or PE reviewed and, if needed, revised. J. On 06/05/24 at 12:19 pm, ED confirmed that the resident evaluation dated 05/24/24 had not yet been reviewed and, if needed revised by an LPN, RN, or PE.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided;	A 026	A 026 7 NMAC 8.2.26 1.Facility Health & Wellness Director will ensure that all assessments and ISP's are completed in a timely manor and signed off by an LPN within 14 days of assessment/ISP being completed. 2.Facility Health & Wellness Director will make appropriate adjustments and changes to residents assessment/ISP as needed for change of condition. 3.Facility Administrator will work with Health and Wellness director to do a monthly audit on all assessments/ISP's to ensure that all have been updated appropriately and that they have been signed off by a LPN. 4. Health & Wellness director will ensure that all Service plans are developed and implemented within 10 days of the admission.	8/12/2024

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A 026	Continued From page 10 (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (2) Based on record review and interview, the facility failed to ensure for 1 (R #9) of 3 (R #s 2, 7, and 9) residents whose Individual Service Plan (ISP) were reviewed for compliance that the ISP's: 1. Was developed and implemented within ten (10) calendar days of admission. 2. Was reviewed and if needed revised by a licensed practical nurse (LPN), registered nurse (RN) or physician extender (PE) These deficient practices could likely result in the resident to be at risk of not getting the care and services needed if the Direct Care Staff (DCS) does not know what the residents' correct needs. The findings are: A. Record review of R #9's (admission date: [redacted] ISP dated [redacted]24 revealed: 1. It was not developed and implemented	A 026		

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A 026	Continued From page 11 within ten (10) calendar days of R #9's admission date. 2. The record did not contain any documentation to show that the ISP was reviewed and, if needed revised by a LPN, RN, or PE. B. Record review of R #9's ISP dated 05/23/24, signed and dated by the Assistant Director of Health and Wellness, revealed the record did not contain any documentation to show that the ISP was reviewed and if needed revised by a LPN, RN or PE. C. On 05/24/24 at 10:19 am, during an interview, the Assistant Director of Health and Wellness confirmed that R #9's ISP's dated 04/18/24 and 05/23/24 were not reviewed or revised by an LPN, RN or PE. D. Record review of R #9's ISP dated 05/24/24 revealed that the record did not contain any documentation that showing that the ISP was reviewed and, if needed, revised by an LPN, RN, or PE. E. On 06/05/24 at 12:19 pm, the Executive Director (ED) confirmed that R #9's ISP dated 05/24/24 had not yet been reviewed and, if needed revised by an LPN, RN, or PE.	A 026	A 032 7 NMAC 8.232 Reporting 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. 2.Director of Health and Wellness and 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. 3Facilily will conduct an internal investigation on all reportable incidents.	7/12/2024
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten	A 032		

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A 032	Continued From page 12 the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. and 8 B. (2) W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin	A 032		

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	7117	A. BUILDING: _____ B. WING _____	C 06/05/2024

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A 032	Continued From page 13 and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on interviews, the facility failed to ensure for 1 (R #9) of 3 (R #s 2, 7 and 9) residents that the facility-reported incidents of unusual occurrence which had or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority within twenty-four (24) hours or by the next business day if it is a weekend or a holiday. This deficient practice could likely result in the residents to be at risk of harm, injury, and/or death if incidents occur and there is no oversight	A 032		

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A 032	Continued From page 14 by the Licensing Authority. The findings are: A. On 05/22/24 at 1:58 pm, during an interview, DCS #11 confirmed: 1. R #9 was new to the facility, had a history of wandering (traveling aimlessly from place to place), tried to find [redacted] family, and is still acclimating (the process in which an individual organism [a single living thing that carries out life activities through organs with separate functions but interdependent on each other] adjusts to a change in its environment) to the facility. 2. On [unknown date], the front desk staff [unknown name] called DCS to alert them that R #9 walked out the front door of the facility. 3. R #9 was located near the bridge on [street name] approximately 0.2 miles away from the facility. 4. DCS [unknown names] had to convince R #9 to come back to the facility, and R #9 stated [redacted] was trying to go back [redacted] daughter's house. B. On 05/24/24 at 9:07 am, during an interview, R #9's son confirmed: 1. R #9 was diagnosed with [redacted] characterized by impairment [redacted] functions, such as memory [redacted] wo years ago and liked to wander the halls in the facility. 2. About a month ago, R #9 had wandered to [street name] approximately 0.2 miles away from the facility, and DCS brought [redacted] R #9) back to the facility. C. On 05/24/24 at 9:40 am, during an interview, the Memory Care Director (MCD) confirmed: 1. There have been a couple of times that	A 032		

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A 032	Continued From page 15 they (staff) have seen R #9 walk outside of the facility and have to redirec[redacted]R #9) back inside. 2. DCS #6 confirmed with[redacted]MCD) that R #9 wanders through the hallway and that[redacted] pack[redacted]uff and says[redacted]ready to leave. D. On 05/28/24 at 10:40 am, during an interview, R #9 confirmed that "about a month ago'[redacted]left the facility and walked to the golf course, and staff [unknown names] brought[redacted]back to the facility. E. On 05/28/24 at 10:40 am, during an interview, R #9's daughter-in-law confirmed that[redacted]had previously been told by staff [unknown names] that R #9 had wandered out of the facility and was found at the golf course by unknown staff. F. On 05/29/21 at 11:27 am, during an interview, DCS #6 confirmed: 1. R #9 does not know why[redacted]s at the facility and will walk around the facility confused. 2. There have been times [unknown date] where[redacted]walked off the property, trying to return home. 3. R #9 will pack[redacted]tuff daily, and walk around the facility with[redacted]bag and suitcase, trying to leave. 4. On an unknown date, R #9 walked out of the facility, and the front desk receptionist saw[redacted]walk out and called DCS on the radio. R #9 walked up the bridge, and DCS [unknown staff] brought[redacted]R #9) back to the facility. G. On 06/03/24 at 4:01 pm, The Director of Health and Wellness confirmed in an email that R #9 incident of leaving the facility and walking to the bridge on [street name] approximately 0.2 miles away, was not reported to the Licensing	A 032		

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A 032	Continued From page 16 Authority by facility staff, and the facility does not have records of this incident.	A 032		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s 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	A 035	A 035 7 NMAC 8.2.35 Medication 1.Facility Health & Wellness director will audit all residents MAR's weekly to ensure that all medications listed on the MAR"s are given as prescribed and in a timely manor. 2. Direct Care staff will ensure that all medications are ordered in a timely manor and will notify Health & Wellness Director of any issues or concerns with getting medications in a timely manor. . 3. Health & Wellness Director will notify resident or family of resident if any issues occur while trying to restock medication. Residents primary care physician will also be notified of any issues or concerns. 4.Facility Administrator will review all residents MAR"s monthly with Director of Health & Wellness to observe any patterns or issue and ensure compliance is being met.	8/12/2024

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A 035	Continued From page 17 primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of 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;	A 035		

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A 035	Continued From page 18 (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (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	A 035		

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A 035	Continued From page 19 packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G Based on record review and interview, the facility failed to ensure for 1 (R #8) of 4 (R #s 2, 3, 4, and 8) residents whose Medication Administration Record (MAR) were reviewed for compliance that all medications listed on the MAR were being given to the resident. This deficient practice could likely result in residents being at risk of harm or illness, if	A 035		

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A 035	Continued From page 20 medications are not given as ordered by the physician and adverse reactions or health complications occur. The findings are: A. Record review of R #8 MAR and medication exception sheet (A document recording the refusal or missing of resident medications) revealed that R #8 did not receive the following medicines on these recorded dates due to the facility not having the medication in stock. 1. [redacted] dates missed: 11/13/2023 through 12/16/2023 2. [redacted] dates missed: 11/13/2023 through 12/16/2023 3. [redacted] dates missed: 11/13/2023 through 12/16/2023 B. On 05/22/24 at 11:12 am in an interview with the Health and Wellness director, she confirmed that the medications for R #8 were missed on the given dates.	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 036	A 036 7 NMAC 8.2.36 Nutrition 1.Dietary Director will retrain all staff on the importance of labeling all perishable items and the proper storage of perishable items. 2. Dietary Director will ensure that all perishable food items are properly labeld and dated, and that all expired items are disposed of in a timely manor. 3. Dietary Director will do a weekly walk through to ensure compliance is being met and that any unlabeled or expired items are disposed of.	8/12/2024

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A 036	Continued From page 21 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. (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	A 036		

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A 036	Continued From page 22 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; (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	A 036		

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A 036	Continued From page 23 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, 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	A 036		

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A 036	Continued From page 24 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. (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.	A 036		

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MORADA ALBUQUERQUE	1620 INDIAN SCHOOL ROAD NE ALBUQUERQUE, NM 87102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 036	Continued From page 25 (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. (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:	A 036		

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A 036	Continued From page 26 7.8.2.36 D (3) Based on observation and interview, the facility failed to ensure food stored in refrigerators and freezers was covered, dated, labeled and not expired. This deficient practice could likely result in the 141 (R #s 1-141) residents listed on the census provided by the Manager on 05/20/24 to be at risk of contracting foodborne illnesses if: 1. The food was not stored properly (covered, dated and labeled). 2. Expired food could be contaminated (to make impure or unsuitable by contact or mixture with something unclean, bad.) with bacteria (microscopic organisms that often play a role in the decay of living things, the process of fermentation, and sometimes in causing disease.) and germs and could cause harm or death to residents. The findings are: A. On 05/24/24 at 10:14 am, during an observation of the kitchen, the following items were used, not covered and dated when opened. 1. 60-ounces bottle of Cranberry juice cocktail not dated. 2. Two (2) 60 oz bottle of apple juice not dated. 3. Stainless steel make table container of cut lemon wedges not dated. 4. Four (4) loaves of bread with mold not dated. 5. One bag of jasmine rice opened, unsealed and not dated. 6. One bag of chicken not dated. 7. One Gallon bag of hotdog's, opened and not dated 8. One small bowl of ice cream uncovered and not dated	A 036		

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A 036	Continued From page 27 9. 14 oz whipped cream not dated 10. One Gallon of whole milk had an expiration of 05/20/24 B. On 05/30/24 at 1:51 pm during an interview with the Administrator, she confirmed that the above items in the kitchen had been located and recorded. She informed the survey team that the culinary director was made aware of the items and disposed of all them immediately.	A 036		
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.42 Based on observation and interview, the facility failed to ensure the building was maintained in presentable condition at all times, and the grounds were kept free from broken windows,	A 042	4 042 7 NMAC 8.2.42 Maintenance of Building and Grounds 1. Facility Maintenance Director will do a walk through of the grounds weekly to ensure that there is no trash or debris present. 2. Facility Maintenance Director will ensure that trash receptacles are free of discarded furniture and miscellaneous items that do not fit properly in trash receptacle. Maintenance director had current items removed and picked up on 6/5/2024. 3. Facility Maintenance Director will do a monthly walk through of community to inspect all windows to make sure they are operational and in good condition undamaged. Maintenance director will replace any damaged windows in a timely manor.	8/12/2024

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A 042	Continued From page 28 accumulation of refuse (solid waste), and discarded furniture. This deficient practice could likely result in the 141 (R #s 1-141) residents listed on the resident census provided by the Administrator on 05/20/24 to be at risk of harm if the facility is not in good repair and free of clutter or environmental hazards. The findings are: A. On 05/23/24 at 9:46 am, during observation of the facility's east side entry path, an accumulation of refuse, including discarded food wrappers and containers and used plastic gloves, was on the walking path. B. On 05/23/24 at 9:48 am, during observation of the facility's east side loading and dumpster area, the following was revealed: 1. Five (5) discarded wooden pallets. 2. One (1) metal two-drawer filing cabinet. 3. Four (4) discarded mattresses. 4. Three (3) discarded mattress box springs. 5. One (1) wooded entertainment center/shelving. 6. One (1) cracked window. C. On 05/23/24 at 12:00 pm, during observation of the hallway on the third floor across from the elevator, one window was observed to be cracked across the interior window pane. D. On 05/23/24 at 12:00 pm, during an interview, the Administrator confirmed a cracked window on the third floor. E. On 05/23/24 at 2:35 pm, during an interview, the Executive Director confirmed the findings	A 042		

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A 042	Continued From page 29 near the east entry walk path and the accumulation of refuse and discarded furniture near the east side loading dumpster area.	A 042		
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: 7.8.2.59 B Based on observation and interview, the facility failed to ensure that all operable windows had screens. This deficient practice could likely result in the	A 059	A 059 7 NMAC 8.2.59 Windows 1.Facility Director of Maintenance will repair and replace all window screens that are damaged or missing. Maintenance Director will also have maintenance staff check window screens upon apartment turns for any tears and or damage so they may be replaced at that time.	8/12/2024

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A 059	Continued From page 30 141 (R #s 1-141) residents identified on the census provided by the Administrator on 05/20/24 to be at risk of illness and/or injury if the residents are subjected to insects, rodents, dust or debris entering through the torn or missing window screens. The findings are: A. On 03/06/24 at 10:38 am, during observation of the facility exterior of the , it revealed that one (1) window screen was missing on the Second (2nd) floor; it is the second window from the Northwest corner. B. On 05/23/24 at 12:00 pm, during an interview, the Administrator confirmed that the window screens listed above were missing.	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.	A 063	A 063 7 NMAC 8.2.63 Fire Extinguishers 1.Facilty Director of Maintenance will perform a monthly inspection of all fire extinguishers. Facilty Maintenance Director will sign off on all extinguishers at the time of inspection. 2. Facility Administrator will do a monthly walk through to ensure that all fire extinguishers have been inspected properly for compliance.	8/12/2024

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A 063	Continued From page 31 [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 NAPA 10, Standard for Portable Fire Extinguishers, 1998 Edition: 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 maintained and inspected monthly as recommended by the manufacturer. This deficient practice could likely result in all 120 (R #s 1-120) residents identified on the census provided by the Administrator on 05/20/24 9:30 am, 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 did not work. The findings are: A. On 05/23/24 at 10:02 am, during observation of the facility, the fire extinguisher located near [redacted] was missing dates and signatures. It had not been inspected (monthly) in compliance with the manufacturer's recommended practice. B. On 05/23/24 at 10:06 am, during observation, the fire extinguisher located across from [redacted] was missing dates and signatures. It had not	A 063		

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A 063	Continued From page 32 been inspected (monthly) in compliance with the manufacturer's recommended practice. C. On 05/23/24 at 10:23 am during observation of the facility, the fire extinguisher near [redacted] was missing dates and signatures. It had not been inspected (monthly) in compliance with the manufacturer's recommended practice. D. On 05/23/24 at 12:00 pm, during an interview with the Administrator, she confirmed that the fire extinguishers listed above did not initial their monthly inspections.	A 063		