STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4017	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEM	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

(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 Complaint survey completed on [redacted]/23 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities for Adults. Census: 15 Complaint Intake [redacted] was investigated with no deficiencies cited.	A 000		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13	A 032	The violation pertaining to failure to report will be corrected by retraining all administration and staff on the definition of a reportable incident to specifically reflect on environmental incidents such as power failures. Specific to this incident, and all other reportable incidents, administration will ensure that any incident and/or power outage that results in a potential safety hazard will be reported to DOH within the 24 hour time frame. Retraining of all staff on reportable incidents, with an emphasis on environmental hazards, will be completed by [redacted]2023, documented and placed in their training file.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4017	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEM	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

(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 032	Continued From page 1 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: Surveyor: [redacted] 7.8.2.32 A([redacted]) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13. & A. (1) (2) W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4017	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEM	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

(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 032	Continued From page 2 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 record review and interview, the facility (Memory Care Unit (MCU) failed to ensure that incidents that could affect the safety and welfare of the residents: 1. Were reported to the Licensing Authority within 24-hours, or the next business day if a holiday or weekend. 2. That internal investigations were conducted by the facility, and investigation follow-up reports were submitted to the Licensing Authority within five (5) business days from the dates the incidents occurred. These deficient practices could likely result in the [redacted] residents identified on the census provided by the Administrator on [redacted]/23 to be at risk of harm, injury, and/or death, if incidents of possible abuse, neglect, exploitation, or unusual occurrence occur and there is no oversight by the Licensing Authority. The findings are: A. Record review of New Mexico Department of Health Complaint Intake [redacted] received on [redacted]22, revealed that the Complainant reported that it was brought to his attention that: 1. A guest (resident's family member) had to crawl out of a window in order to leave the facility when there was a power outage and the facility doors remained locked.	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4017	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEM	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

(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 032	Continued From page 3 2. There was no staff to assist the guest and she was forced to climb out a window at the facility. B. On [redacted]/23 at 10:52 am, during an interview, [Name of Family Member] stated that sometime in [redacted] 2022, the facility experienced a power outage, whereby the facility doors malfunctioned and remained locked. The family member had to exit the building through a window, prompting a fire safety hazard for all residents, if there was a fire or other emergency that required evacuation. The family member stated there was adequate staff on duty, however, she was concerned that if the doors remained locked instead of unlocking during a an emergency, would the staff be able to safely evacuate the residents. C. Record request for the facility's Internal Incident Reports and other documentation related to a power outage at the facility on [redacted]/22, revealed no documentation that the facility: 1. Reported the incident of the facility power being out for 7 hours (10:00 am-5:00 pm, per House Manager) on [redacted]/22 and the doors remaining locked instead of unlocking to the Licensing Authority within 24 hours or the next business day if it is a holiday or a weekend. 2. That an internal investigation was conducted by the facility, and an Investigation/Follow-up report was submitted to the Licensing Authority within five (5) business days from the dates the incident occurred. D. On [redacted]/23 at 1:00 pm, during an interview with the on-call Administrator (from a sister facility) confirmed that the incident of the power outage did occur (exact date unknown), but was not told by staff that the MCU doors had malfunctioned (locked instead of unlocked). She stated, she did not know the extent of the outage	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4017	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEM	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

(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 032	Continued From page 4 and she had not called the electric company. She stated, she instructed facility staff to gather the residents in a common area, secure portable oxygen tanks and have flash lights available. She stated as far as she was aware, no residents experienced injuries as a result of the outage. The on-call Administrator confirmed that she: 1. Did not report the incident that effected the entire facility and had the potential for resident harm to the Licensing Authority within 24-hours, or the next business day if a holiday or weekend. 2. The facility did not conduct an internal investigation or submit a Investigation/Follow-Up Report to the Licensing Authority within five (5) business days from the date the incident occurred. E. On [redacted]/23 at 8:30 am, during an interview, [Name of door company service staff] stated the doors have a fail/safe mechanism to ensure the doors stay unlocked if the electricity goes out, however, the mechanism malfunctioned during the incident-causing the doors to remain locked. He stated he did install latches onto the facility doors so staff can manually lock/unlock the doors as a precautionary measure. F. On [redacted]/23 at 9:00 am, during an interview, the House Manager stated the power outage possibly occurred in [redacted]2022, (later it was confirmed by Administrator that the incident occurred on [redacted]22), but did not know for sure. She recalled the facility was fully staffed and the outage lasted from 10:00 am to 5:00 pm. She stated all doors were checked and remained locked, therefore, staff and one visitor had to exit/arrive through a window. She stated she did not create a facility Internal Incident Report nor file a report with Licensing Authority.	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4017	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEM	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

(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 032	Continued From page 5 G. Record review of a written statement dated [redacted]/23, from the temporary facility Maintenance Man, revealed he arrived at the facility on [redacted]/22 at 2:00 pm, and was able to manually pry the facility doors open, thereby, decreasing the fire safety hazard. He stated, the lights came back on around 5:00 pm and no residents appeared to be injured as a result of the outage. H. On [redacted]/23 at 11:31 am, during an interview with the facility Administrator, she confirmed the incident occurred on [redacted]/22. She stated a facility maintenance staff arrived to the facility on the day (unknown time) of the incident and was able to manually pry the doors open, thereby, decreasing the fire safety hazard. She confirmed that the facility did not: 1. Report the incident to the Licensing Authority within 24 hours of the next business day, if it was a holiday or weekend. 2. Conduct an internal investigation and/or submit an Investigation/Follow-Up report to the Licensing Authority within 5-business days from the date the incident occurred.	A 032		
A 049	7 NMAC 8.2.49 Doors DOORS: A. No door in any means of egress shall be locked against egress when the building is occupied. (1) Exit doors may be provided with a night latch, dead bolt, or security chain, provided these devices are operable from the inside, by any occupant, without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed forty-eight (48) inches above the finished floor. (2) If locks are not readily operable by all	A 049	All violations pertaining to the doors not unlocking due to a power outage was corrected by the fire safety company coming into the community and servicing the back-up battery and providing an inservice to administration on how to recognize and replace batteries. The facility will monitor this corrective action and ensure ongoing compliance by adding battery testing to the 30 day routine maintenance schedule. The corrective action will be completed by [redacted]/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4017	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEM	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

(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 049	Continued From page 6 occupants within the building, the locks must: 1) unlock upon activation of the fire detection or sprinkler system and 2) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written approval from the building, fire and licensing authorities having jurisdiction. B. All exit doors shall have a minimum width of thirty-six (36) inches. (1) Facilities with a capacity of ten (10) or more residents shall have exit doors leading to the outside of the facility that open outward. (2) Facilities with a capacity of fifty (50) or more residents must provide panic hardware at the exit doors. (3) No door or path of travel to a means of egress shall be less than twenty-eight (28) inches wide. C. All resident sleeping room doors must be at least one and three-quarters (1 3/4) inch solid core construction. D. Bathroom doors may be twenty-four (24) inches wide. Facilities with four (4) or more residents shall have at least one bathroom for every eight (8) residents with a door clearance of thirty-six (36) inches for access by persons with disabilities. E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside. F. All doors shall readily open from the inside. G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms. [7.8.2.49 NMAC - Rp, 7.8.2.50 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.49 F Based on record review and interview the facility	A 049		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4017	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEM	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

(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 049	Continued From page 7	A 049		

failed to ensure that the doors to enter and exit the building could be readily open from the inside of the facility.

This deficient practice resulted in the [redacted] Memory Care Unit (MCU)residents identified on the census provided by the Administrator on [redacted]23, not being able to exit the building through the doors to the outside during a power outage, because the doors malfunctioned and locked instead of unlocking.

The findings are:

A. Record review of New Mexico Department of Health Complaint Intake [redacted] received on [redacted]22, revealed that the Complainant reported that it was brought to his attention that:
1. A guest (resident's family member) had to crawl out of a window in order to leave the facility when there was a power outage and the facility doors remained locked,
2. There was no staff to assist the guest and she was forced to climb out a window at the facility.

B. On [redacted]23 at 10:52 am, during an interview, [Name of Family Member] stated that sometime in [redacted]2022, the facility experienced a power outage, whereby the facility doors malfunctioned and remained locked. The family member had to exit the building through a window, prompting a fire safety hazard for all residents, if there was a fire or other emergency that required evacuation. The family member stated there was adequate staff on duty, however, she was concerned that if the doors remained locked instead of unlocking during a an emergency, would the staff be able to safely evacuate the residents.

C. Record request for the facility's Internal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4017	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEM	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

(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 049	Continued From page 8 Incident Reports and other documentation revealed that there was power outage at the facility on [redacted]22. The power was out for 7 hours (10:00 am-5:00 pm, per House Manager) and the doors malfunctioned and locked instead of unlocking the doors. D. On [redacted]23 at 1:00 pm, during an interview with the on-call Administrator (from a sister facility) confirmed that the incident of the power outage did occur (exact date unknown), but was not told by staff that the MCU doors had malfunctioned (locked instead of unlocked). She stated, she did not know the extent of the outage and she had not called the electric company. She stated, she instructed facility staff to gather the residents in a common area, secure portable oxygen tanks and have flash lights available. She stated as far as she was aware, no residents experienced injuries as a result of the outage. E. On [redacted]23 at 8:30 am, during an interview, [Name of door company service staff] stated the doors have a fail/safe mechanism to ensure the doors stay unlocked if the electricity goes out, however, the mechanism malfunctioned during the incident-causing the doors to remain locked. He stated he did install latches onto the facility doors so staff can manually lock/unlock the doors as a precautionary measure. F. On [redacted]23 at 9:00 am, during an interview, the House Manager stated the power outage possibly occurred in [redacted]2022, (later it was confirmed by Administrator that the incident occurred on [redacted]22), but did not know for sure. She recalled the facility was fully staffed and the outage lasted from 10:00 am to 5:00 pm. She stated all doors were checked and remained locked, therefore, staff and one visitor had to	A 049		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4017	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEM	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

(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 049	Continued From page 9 exit/arrive through a window. G. Record review of a written statement dated [redacted]/23, from the temporary facility Maintenance Man, revealed he arrived at the facility on [redacted]/23 at 2:00 pm, and was able to manually pry the facility doors open, thereby, decreasing the fire safety hazard. He stated, the lights came back on around 5:00 pm and no residents appeared to be injured as a result of the outage. H. On [redacted]/23 at 11:31 am, during an interview with the facility Administrator, she confirmed the incident occurred on [redacted]/22. She stated a facility maintenance staff arrived to the facility on the day (unknown time) of the incident and was able to manually pry the doors open, thereby, decreasing the fire safety hazard.	A 049		
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	A 063	In order to correct this deficiency, all fire extinguishers were checked and initialed, fire maintenance company put new tags on all extinguishers during their visit on [redacted] This will be monitored by maintenance checking and logging monthly Deficiency was corrected on [redacted]	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4017	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEM	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

(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 063	Continued From page 10 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: 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. 7.8.2.63 B Based on observation and interview, the facility failed to ensure that the facility fire extinguishers were being maintained and inspected monthly as recommended by the manufacturer. This deficient practice could likely result in all [redacted] residents identified on the census provided by the Administrator on [redacted]23, staff members, and other 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 [redacted]/23 at 10:30 am, during observation: 1. The facility's fire extinguishers located in the kitchen, living room, dining room, and West hallway, had not been inspected by staff monthly since [redacted] 2023 as recommended by the manufacturer.	A 063		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4017	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEM	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

(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 063	Continued From page 11 2. That the manual pull system for the range hood, had not been inspected monthly facility staff since the annual inspection in [redacted] 2023. B. On [redacted]23 10:50 am, during an interview, Direct Care Staff #5 confirmed that the: 1. Fire extinguishers in the kitchen, living room, dining room, and West hallway had not been inspected monthly by staff since [redacted], 2023. 2. The manual pull system for the range hood had not been inspected monthly by facility staff since [redacted] of 2023.	A 063		