

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5873	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/11/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARISTOCRAT OPERATING COMPANY I, LLC

**252 ROBERT H BRADLEY DRIVE
ALAMOGORDO, NM 88310**

(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
8 000	Initial Comments Deficiencies were cited during a Complaint survey completed on 09/11/25 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living for Adults. Census: 47 34 ALF, 13 MC Complaint Intake NM [REDACTED] was investigated with deficiencies cited Complaint Intake NM [REDACTED] was investigated with no deficiencies cited Complaint Intake NM [REDACTED] was investigated with no deficiencies cited	8 000		
8 033	8 NMAC 370.14.33 Resident Rights All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident's understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or	8 033		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Proseana Dyer RN Administrator 10/11/25

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8 033	Continued From page 1 (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident's medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation;	8 033			

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8 033	Continued From page 2 (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a 15 calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within 14 calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility;	8 033			

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8 033	Continued From page 3 and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident's surrogate decision maker and outlined in the resident's individual service plan. [8.370.14.33 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.33.D (1) Based on record reviews and interview, the facility failed to ensure for 1 (R #5) of 3 (R #1, R #5 and R #7) residents were treated with courtesy, respect, dignity and compassion and were free from emotional abuse. This deficient practice could likely place residents at risk for developing long-term mental health damage and could contribute to the decline of their physical health. The findings are: A. Record review of Complaint Intake NM [REDACTED] received on [REDACTED]/25 revealed the following: 1. On [REDACTED] 25, the Director was shown a video where R #5 was on the floor in [REDACTED] bedroom. 2. Direct Care Staff (DCS) #8 entered the room laughed at R #5 on the floor, lowered herself, and shook her hand at R #5 and did not ask if [REDACTED] ok or check for injuries. 3. DCS #8 tried to lift R #5 but was unable to lift the resident and required assistance from DCS #9. 4. The Director terminated DCS #8 on	8 033	<i>At the time of infraction, employee was terminated immediately.</i> <i>Every 2 months Inservice will be done on Resident Rights, which are included in Resident Agreement form on Admission Date.</i> <i>This will emphasize the residents are treated with courtesy, respect, dignity, compassion, and free from abuse or neglect.</i> <i>10/11/25</i> <i>October 11, 2025</i>		

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8 033	Continued From page 4 [REDACTED]/25 due to mistreatment/taunting behavior s in the video. B. Record review of DCS #8's employee file revealed DCS #8 was terminated due to eatment of a resident that occurred on [REDACTED]/25 where DCS #8 was seen on a bedroo ra pointing and laughing at R#5 because [REDACTED] had fallen on the floor. DCS #8 never [REDACTED] d [REDACTED] #5 with any care, or concern to see if [REDACTED] ok or in pain. C. On 09/09/25 at 2:32 pm during an interview, the Director reported the following: 1. On 07/23/25, she was notified by R #5's son that he viewed the bedroom camera and seen R #5 had fallen on the floor. 2. She observed the video on R #5 son's phone and saw R #5 on the floor and DCS #8 came into the room and was laughing at the resident. DCS #8 also began to point and [REDACTED] ke her hand at R #5 and was still laugh [REDACTED]. DCS #8 never [REDACTED] ed the resident if [REDACTED] s k or even [REDACTED] cked [REDACTED] for injuri [REDACTED] DCS [REDACTED] en tried to lift [REDACTED] from [REDACTED] floor by [REDACTED] arm. 3. R #8 was terminate effective immediately due to her mistreatment/taunting behavior of R #5.	8 033			